



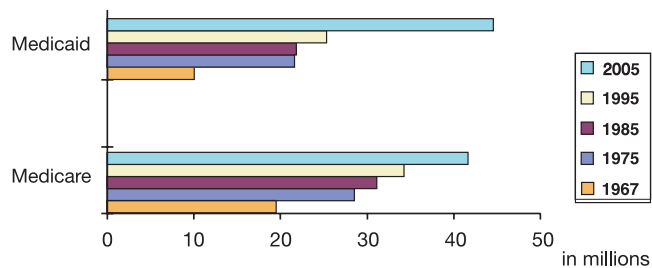
# CMS Financial Report

Fiscal Year 2005

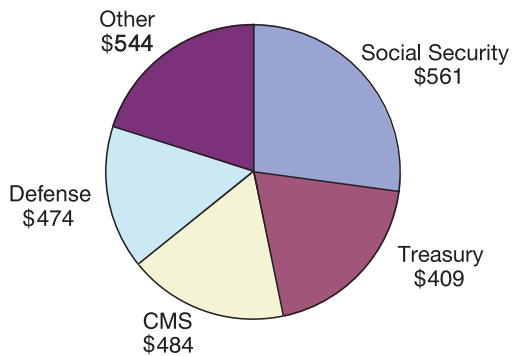
# THE CENTERS FOR MEDICARE & MEDICAID SERVICES AT A GLANCE

The **CMS** is one of the largest purchasers of health care in the world. The Medicare, Medicaid, and State Children's Health Insurance programs that we administer provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 42 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 44.7 million beneficiaries.

**2005 Program Enrollment**



**2005 Federal Outlays**



Source: U.S. Treasury

\$ in billions

The **CMS** outlayed approximately \$484.3 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2005, approximately 20 percent of total Federal outlays. The only agency that outlayed more is the Social Security Administration.

The **CMS** has approximately 4,750 Federal employees, but does most of its work through third parties. The CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. The CMS also assures the safety and quality of medical facilities, provide health insurance protection to workers changing jobs, and maintain the largest collection of health care data in the United States.



### ***A Message from the Administrator***

This fiscal year not only marks the 40th anniversary of Medicare and Medicaid, it also reflects the Centers for Medicare & Medicaid Services' (CMS) continued efforts to improve our business and make significant changes that benefit our beneficiaries, customers and stakeholders. Meeting CMS' mission, vision, and goals is an awesome task and an increasingly complex challenge. However, CMS has met every challenge head on. We have kept to our vision, *"in serving beneficiaries, we will open our programs to full partnership with the entire health community to improve quality and efficiency in an evolving health care system"* in a number of ways. These efforts are conveyed in the annual ***CMS Financial Report*** for fiscal year (FY) 2005, which I am proud to present.

In FY 2005 CMS implemented the greatest changes to Medicare since its inception. We reviewed and approved prescription drug plans that cover all medically necessary treatments with premiums that were lower than expected, and with benefit options that are better than generally expected, providing better coverage and more drug savings for Medicare beneficiaries in 2006. We expanded the Medicare Advantage program providing comprehensive coverage options and lower out-of-pocket costs to more Medicare beneficiaries than ever before. We partnered with Federal and State Government agencies, community organizations, patient advocacy groups, and the pharmaceutical industry for our education and outreach campaigns on Medicare's new benefits. These campaigns will help Medicare beneficiaries get the comprehensive, consistent, and timely information and guidance to make confident, informed, and straightforward decisions about their health care choices.

We are also ahead of schedule in our plan for implementing the Medicare contractor reform provisions outlined in the Medicare Modernization Act. In the future fee-for-service environment, Medicare Administrative Contractors will assume the work currently performed by fiscal intermediaries and carriers, and serve as providers' primary point-of-contact for the receipt, processing, and payment of claims. The President's Budget projects that this plan could save the Medicare trust funds a total of \$900 million by the end of FY 2010.

The CMS' Quality Roadmap defines the Agency's strategies to address the transformation of health care in the Nation. These strategies will help promote changes in health care organizations that will lead to improvements in health care quality and the lives of our beneficiaries. Transforming the health care system will require CMS to work in partnership with traditional and non-traditional partners. This past year, CMS worked with these partners to establish the quality standards which will be the cornerstone of our health care transformation.

We continued to demonstrate our strong commitment to safeguarding the Medicare trust funds by developing aggressive corrective actions to reduce the number of payments errors in the Medicare program. Through aggressive monitoring efforts of our Medicare contractors we were able to achieve dramatic results to reduce Medicare payment errors this year. Our focused attention on these activities resulted in a significant reduction in payment errors of 49 percent compared to last year's error rate. This year's error is 5.2 percent, a great accomplishment in CMS' continuing efforts to secure Medicare trust funds for the future.

In the wake of the natural disaster that occurred this year, CMS immediately responded to the changing priorities resulting from the Public Health Emergency for Hurricane Katrina stricken areas. The CMS tackled the monumental task of providing relief to affected beneficiaries and providers by working around the clock with other Federal and State agencies to immediately address providing health care benefits promptly to the elderly, children, and persons with disabilities; expediting payments to providers; and rebuilding health care infrastructure.

This just begins to describe the numerous efforts and achievements that CMS put forth during FY 2005. We are using the results of this audit to further enhance and improve our efforts with regard to the managed care program. Many of the items are currently underway and we have a comprehensive roadmap for continuous improvement. We are developing a comprehensive managed care oversight function. We've also begun designing a robust set of analytics to review the monthly plan payments at the beneficiary level and are in the process of conducting a comprehensive review of all policies and procedures to ensure they all meet statutory requirements and are adequately documented. As we face the upcoming challenges in the new fiscal year, we will continue to work with all of our partners—Congress, the States, our beneficiaries, and the health care community—to ensure that our programs are strong, efficient, well managed, and of high quality. This Agency continues to successfully accomplish numerous new initiatives while continually fulfilling its mission. For that, I thank all who have worked to ensure this year's successes. In the end, we are all mindful that all of our hard work has but one focus: *assuring the health care security of our beneficiaries and helping our health care system deliver the right care every time.*



Mark B. McClellan, M.D., Ph.D.  
November 2005



### ***A Message from the Chief Financial Officer***

As CMS' Chief Financial Officer (CFO), I am pleased to report that we have continued our tradition of excellence by making significant progress in financial and performance management during FY 2005. Not only did we receive an unqualified opinion on our financial statements for the seventh straight year, but we have been able to effectively implement corrective actions that have eliminated several of our material weaknesses. The CMS made a concerted effort to strengthen its fiscal management and accountability by enhancing internal controls and many initiatives were undertaken in FY 2005 to validate our financial success:

- We have shown even greater improvement in how we do business by reducing the number of Medicare payment errors. We have aggressively taken corrective action and improved our monitoring efforts of the Medicare contractors, further reducing the Medicare Error Rate. Our focused attention on these activities resulted in a dramatic reduction in payment errors by 49 percent based on last year's error rate. This year's error rate is 5.2 percent. This is a great accomplishment and proves that CMS is continuing in the right direction to ensure the safeguarding of Medicare trust funds.
- We established the CMS Risk Management and Financial Oversight Committee to assist in the oversight responsibilities for CMS' financial statements, compliance with legal and regulatory requirements, and the proper functioning of internal controls. We have collaborated with the OIG to implement corrective action plans for prior weaknesses and deficiencies identified by our auditors.
- We significantly improved efficiencies in Information Technology (IT) management and internal controls. As a direct result of CMS' intensified efforts to improve IT governance, our auditors have reported significant improvement in the systems security area, which resolved CMS' long-standing IT material weakness.
- We expanded our program integrity efforts to include the oversight of Medicaid and the State Children's Health Insurance Program (SCHIP) by issuing an interim final regulation for the Medicaid Error Rate program. In addition, we continue to refine and enhance our methodology that was designed to measure payment errors in Medicaid and SCHIP in both the fee-for-service and managed care components of these programs. The CMS' program integrity efforts are being expanded beyond fee-for-service Medicare to encompass oversight of the prescription drug benefit, and the new Medicare Advantage plans.

- We increased efficiencies in financial management by implementing the Healthcare Integrated General Ledger Accounting System (HIGLAS) at four Medicare contractor sites, and generating savings to date exceeding \$627.5 million. We continue to make progress toward the full implementation of HIGLAS, which is a key element of our strategic vision to implement a complete, financial management system that integrates CMS accounting systems with those of our Medicare contractors.

As the CFO, I take CMS' financial management responsibilities very seriously. While we are proud of our accomplishments in FY 2005, we must continue to strengthen and improve all aspects of our performance. Our goal is to not just maintain, but exceed CMS' high financial management standards in FY 2006. Even with the great strides CMS made this fiscal year, we know there is still a lot of work that must be done. We are working hard to develop and implement the financial and programmatic tools we need to continue to provide reliable information regarding the administration of CMS' programs. We will continue to work diligently to improve our financial management performance in all areas, especially those areas identified as material weaknesses by our auditors.

A handwritten signature in black ink, appearing to read "Timothy B. Hill", with a long horizontal line extending from the top of the signature.

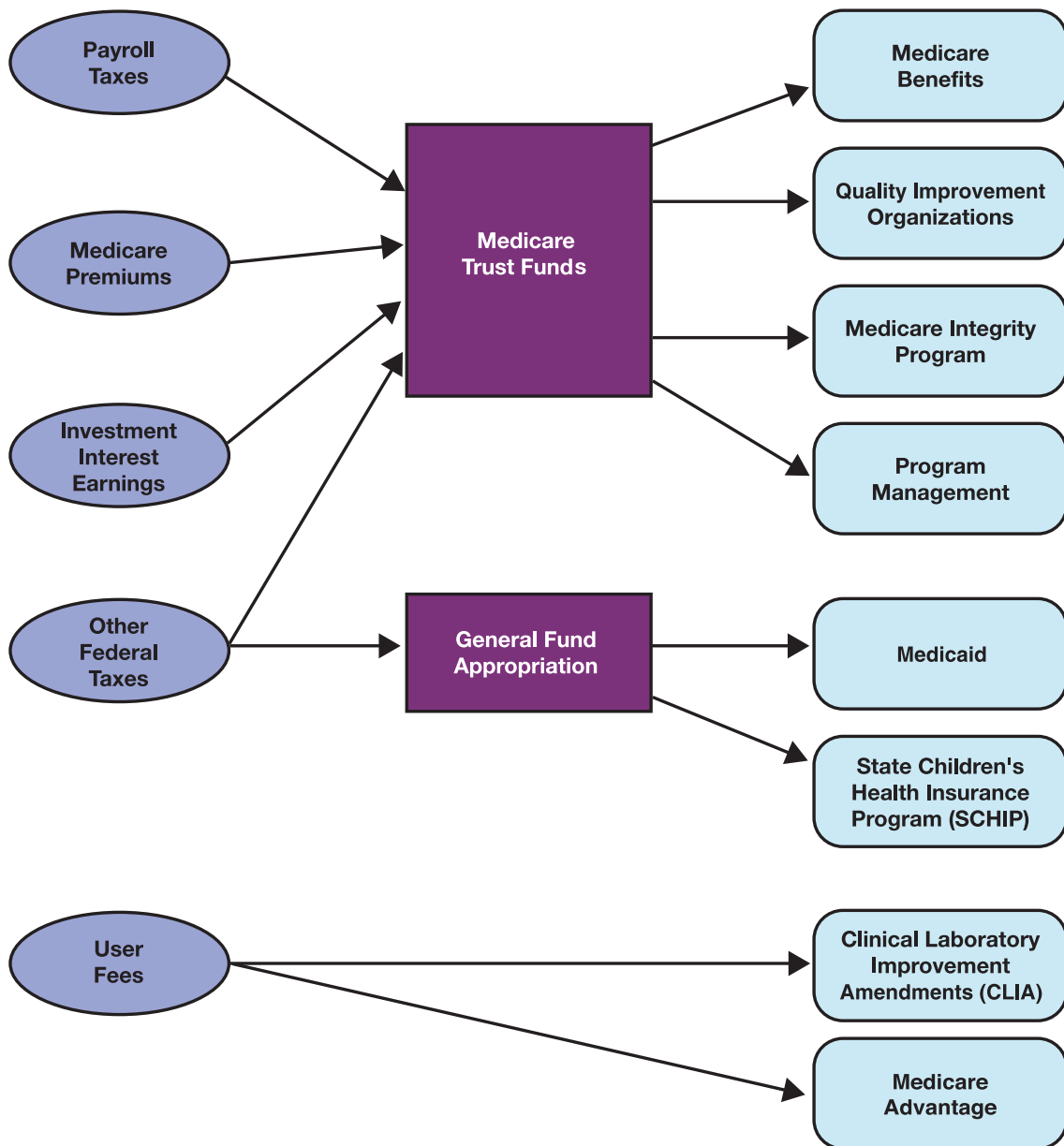
Timothy B. Hill  
November 2005

# FINANCING OF CMS PROGRAMS AND OPERATIONS

Funds Flow From ...

... Through ...

... To Finance ...



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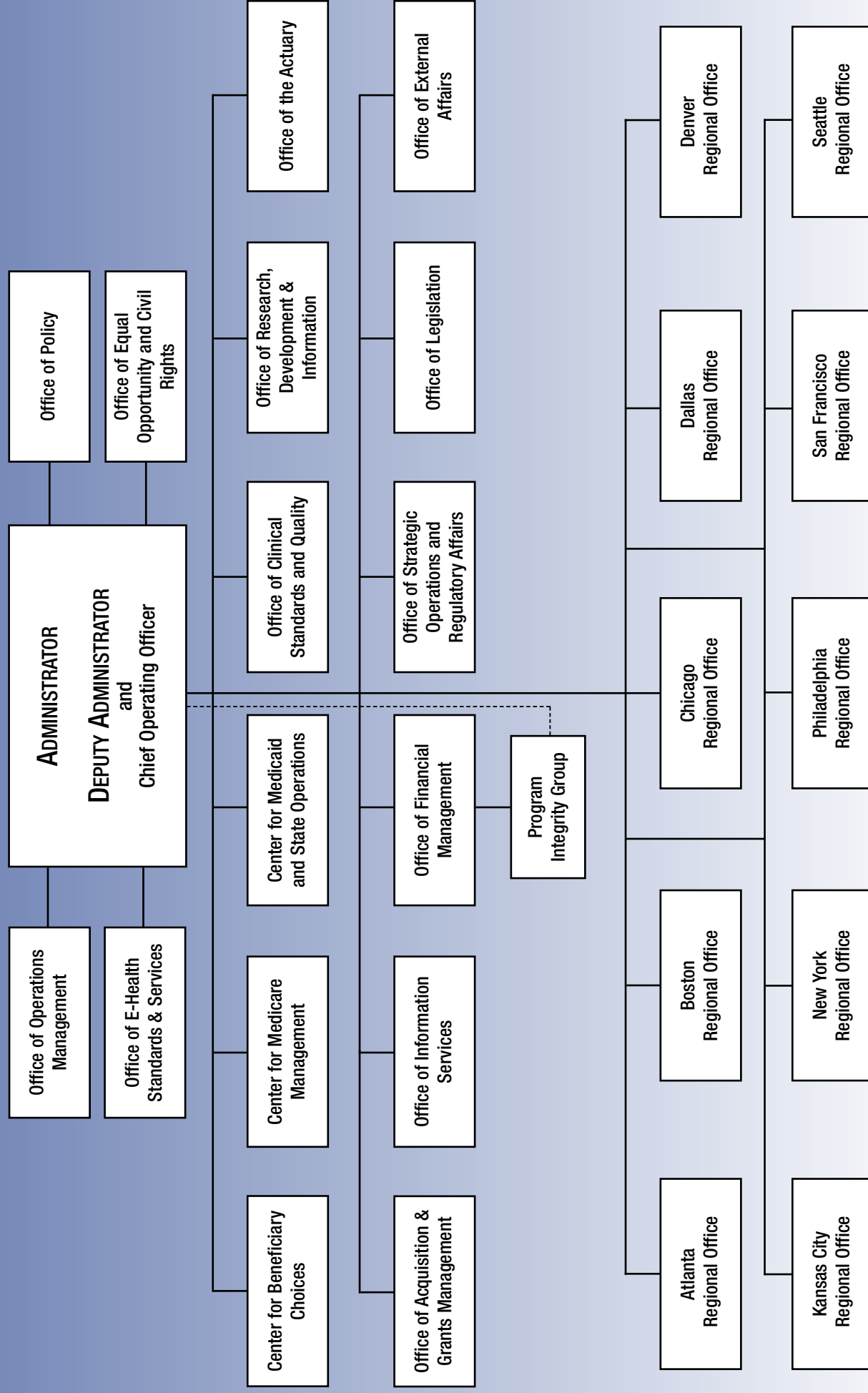
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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES



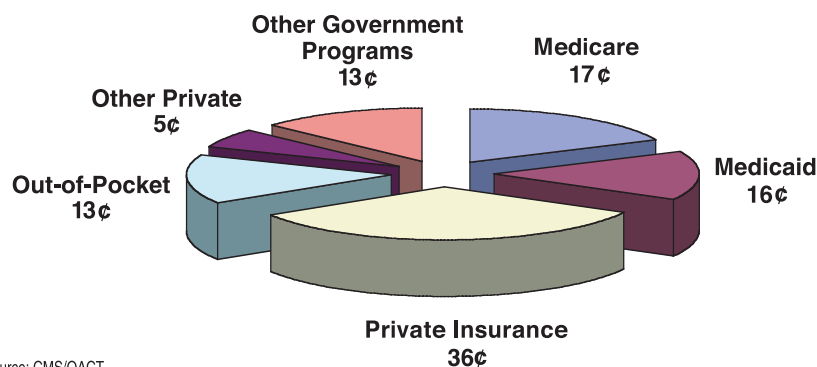
# Management's Discussion and Analysis

## OVERVIEW

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Along with the Departments of Labor and Treasury, CMS also implements the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The CMS is one of the largest purchasers of health care in the world. Based on the latest projections, Medicare and Medicaid (including State funding), represent 33 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 59 cents of every dollar spent on nursing homes, 48 cents of

**The Nation's Health Care Dollar 2005**



Source: CMS/OACT

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

every dollar received by U.S. hospitals, and 28 cents of every dollar spent on physician services.

The CMS **outlays** totaled approximately \$484.3 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2005. Our **expenses** totaled \$521.7 billion, of which \$2.9 billion (less than 1 percent) were administrative expenses.

The CMS establishes policies for program eligibility and benefit coverage, processes over one billion Medicare claims annually, provides States with funds for Medicaid and SCHIP, ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse. The CMS employs approximately 4,750 Federal employees in Baltimore, Maryland, Washington, DC, and 10 regional offices (ROs) throughout the country. The RO employees mainly provide direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. The employees in Baltimore and Washington provide funds to Medicare contractors; write policies and regulations; set payment rates; safeguard the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for medically necessary services are paid correctly the first time; recover improper payments; assist law enforcement agencies in the prosecution of fraudulent activities; monitor contractor performance; develop and implement customer service improvements; provide education and outreach activities to beneficiaries and Medicare providers, survey hospitals, nursing homes, labs, home health agencies and other health care facilities for compliance with Medicare health and safety standards; work with state insurance companies; and assist the States and Territories with Medicaid and SCHIP. The CMS also maintains the Nation's largest collection of health care data and provides technical assistance to the Congress, the executive branch, universities, and other private sector researchers.

Many important activities are also handled by third parties. The States administer the Medicaid program and SCHIP, as well as inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare contractors process Medicare claims, provide technical assistance to providers and service beneficiaries' needs, and respond to inquiries. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

**Expenses** are computed using the accrual basis of accounting that recognizes costs when incurred and revenues when earned regardless of the timing of cash received or disbursed. Expenses include the effect of accounts receivable and accounts payable on determining the net cost of operations. **Outlays** refer to cash disbursements made to liquidate an expense regardless of the fiscal year the expense was incurred.

# PROGRAMS

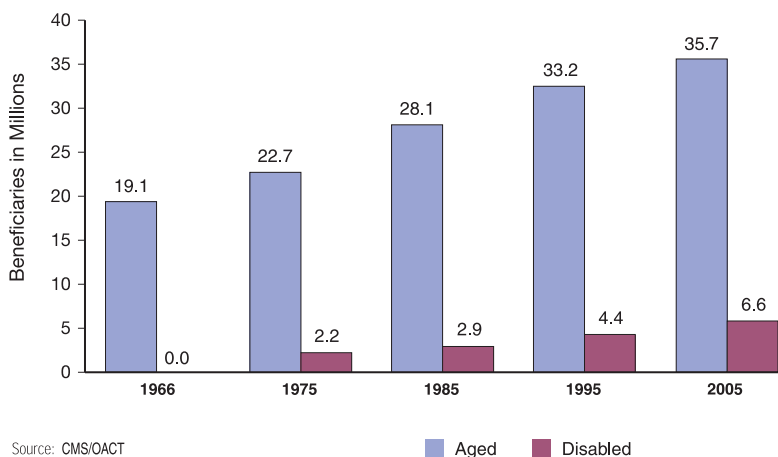
## Medicare

### Introduction

Established in 1965 as title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older that elect Medicare coverage.

Medicare processes over one billion fee-for-service (FFS) claims a year, is the Nation's largest purchaser of managed care, and accounts for almost 12 percent of the Federal Budget. Medicare is a combination of three programs: Hospital Insurance, Supplementary Medical Insurance, and Medicare Advantage. Since 1966, Medicare enrollment has increased from 19 million to approximately 42 million beneficiaries.

Medicare Enrollment



In December 2003, the President signed legislation to improve and modernize the Medicare program, including the addition of a drug benefit. This legislation—the Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA)—represents the largest change to the Medicare program since its enactment in 1965. The diverse impacts of MMA are reflected in the various sections of this report.

### Hospital Insurance

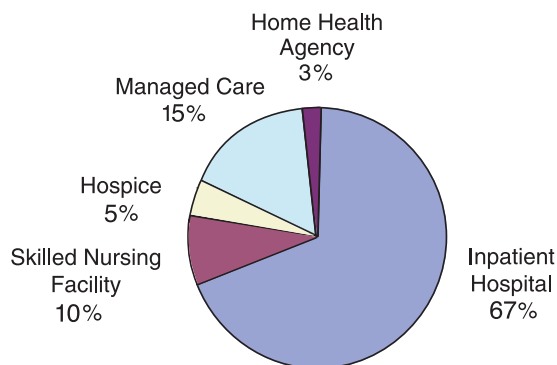
Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

Based on estimates from the Mid-Session Review of the FY 2006 President's budget, inpatient hospital spending accounted for 67 percent of HI benefit outlays. Managed care spending comprised 15 percent of total HI outlays. During FY 2005, HI benefit outlays grew by 9.4 percent and the HI benefit outlays per enrollee were projected to increase by 7.8 percent to \$4,300.

### HI Medicare Benefit Payments

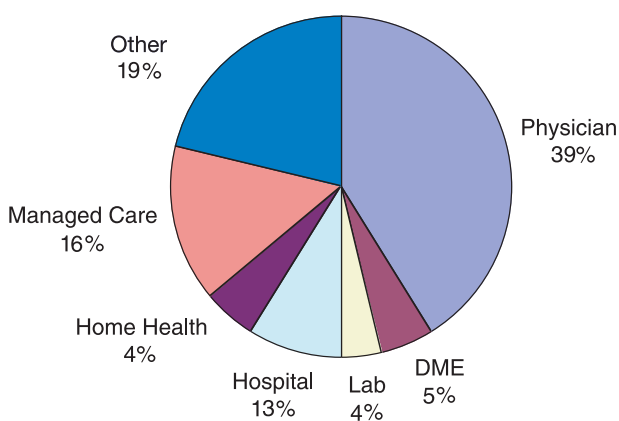


Source: CMS/OACT

### Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B and Medicare Part D, is available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, Medicare prescription drug discount card enrollment fees and prescription drug expenses for Transitional Assistance beneficiaries, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 94 percent of HI enrollees elect to enroll in SMI.

### SMI Medicare Benefit Payments



Source: CMS/OACT

The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund, and invested in U.S. Treasury securities.

Also based on estimates SMI benefit outlays grew by 11.6 percent during FY 2005. Physician services, the largest component of SMI, accounted for approximately 39 percent of SMI benefit outlays. During FY 2005, the SMI benefit outlays per enrollee were projected to increase 10.2 percent to \$3,730.

## **CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005**

### ***Medicare Advantage***

The MMA created the Medicare Advantage (MA) program, which is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are entitled because of age (65 or older) or disability may choose to join a MA plan if they are entitled to Part A and enrolled in Part B, if there is a plan available in their area. Those who are entitled to Medicare because of ESRD may join a MA plan only under special circumstances.

Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional FFS arrangements. MA plans have their own providers or a network of contracting health care providers who agree to provide health care services for health maintenance organizations (HMO) or prepaid health organizations' members. MA plans currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and a private FFS plan. MA demonstration projects, as well as cost and Health Care Prepayment Plans (HCPPs) options, also exist.

All MA plans are currently paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare covered services. Many MA plans offer additional services such as prescription drugs, vision and dental benefits to beneficiaries. Cost contractors are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services, but do not always provide the additional services that some risk MA plans offer. The HCPPs are paid in a manner similar to cost contractors, but cover only non-institutional Part B Medicare services. Section 1876 cost-based contractors and HCPPs, with certain limited exceptions, phase out under the current provisions.

Managed care expenses were \$44.5 billion of the total \$329.8 billion in Medicare benefit expenses in FY 2005.

## **Medicaid**

### ***Introduction***

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly, the blind, and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. The average enrollment for Medicaid was estimated at 44.7 million in FY 2005, about 15 percent of the U.S. population. About 7 million people are dually eligible, that is, covered by both Medicare and Medicaid.

The CMS provides matching payments to the States and Territories to cover the Medicaid program and related administrative costs. State medical assistance payments are matched

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

according to a formula relating each State's per capita income to the national average. In FY 2005, the Federal matching rate for Medicaid program costs among the States according to the formula ranged from 50 to 77 percent. The average matching rate for FY 2005 was about 57 percent. Federal matching rates for various state and local administrative costs are set by statute, and currently average about 55 percent. Medicaid payments are funded by Federal general revenues provided to CMS through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to the States, except with respect to the disproportionate share program and payments to territories.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled, blind, and elderly population), low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning services, nursing facility services, and comprehensive health services for individuals under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to its individual circumstances and priorities. Accordingly, there is a wide variation in the services offered by the States.

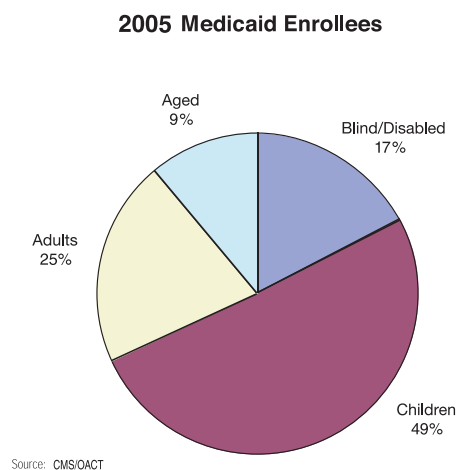
Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2005 is estimated to be about \$10.4 billion in Federal and State funds. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration (FDA) for treatment of AIDS.

### Payments

Under Medicaid, state payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with Federal funds. In FY 2005, State and Federal ADM gross outlays are estimated at \$17 billion, about 5.2 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at \$309.4 billion or 95 percent of total Medicaid gross outlays, an increase of 9.2 percent over FY 2004. Thus, State and Federal MAP and ADM outlays for FY 2005 totaled \$326.4 billion. The CMS share of Medicaid expenses totaled \$182.2 billion in FY 2005.

### Enrollees

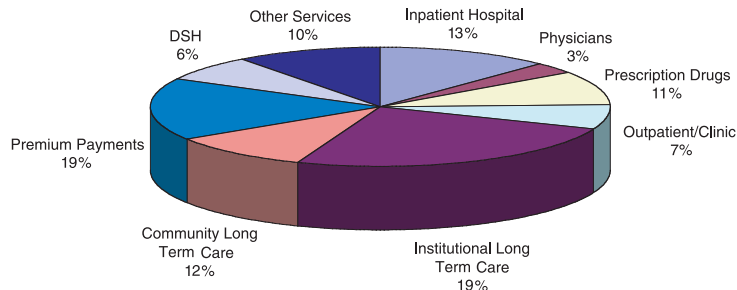
Children comprise nearly half of Medicaid enrollees, but account for only 18 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 26 percent of Medicaid enrollees, but accounted for 64 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.



## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

### Medicaid Medical Assistance Payments FY 2005

Total Payments = \$311 billion



Source: CMS/OACT

### ***Service Delivery Options***

Many States are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their State and local needs, and 47 States now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 15 percent in 1993 to over 60 percent in 2004.

The CMS and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Moreover, as a result of the Balanced Budget Act of 1997 (BBA), the States may amend their State plan to require certain Medicaid beneficiaries in their State to enroll in a managed care program, such as a managed care organization or primary care case manager. Medicaid law provides for two kinds of waivers of existing Federal statutes and two other options through the State plan process to implement managed care delivery systems.

- 1) State health reform waivers—Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. In August 2001, the President announced a section 1115 initiative, known as Health Insurance Flexibility and Accountability, to increase health insurance coverage by coordinating available Medicaid and SCHIP funding with private insurance options.
- 2) Freedom of choice waivers—Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow the States to develop innovative managed health care delivery systems.
- 3) Other State plan options to implement managed care—Section 1932(a) of the Social Security Act allows States to mandate managed care enrollment for certain groups of Medicaid beneficiaries. Certain populations—including dual eligibles, children receiving SSI, children with special health care needs, and American Indians—are exempted from the State plan option. For these groups, the States require waivers to mandate enrollment into managed care.

## **CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005**

States may also elect to include the Program of All-Inclusive Care for the Elderly (PACE) as a State plan option. The PACE is a prepaid, capitated plan that provides comprehensive health care services to frail, older adults in the community, who enroll on a voluntary basis, and who are eligible for care in nursing homes according to State standards.

### **State Children's Health Insurance (SCHIP)**



SCHIP was created through the BBA to address the fact that nearly 11 million American children—one in seven—were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside nearly \$40 billion over ten years, beginning in FY 1998, to create SCHIP—the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage. Important cost-sharing protections were also established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets the broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, use existing comprehensive state-based coverage, or provide coverage approved by the Secretary of HHS.

States also have the opportunity to set eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that State programs meet statutory requirements that are designed to ensure meaningful coverage under the program.

The CMS works closely with the States, Congress, and other Federal agencies to meet the challenges of implementing this program. The CMS provides extensive guidance and technical assistance so the States can further develop their plans and use Federal funds to provide health care coverage to as many children as possible. Since September 30, 1999, all 50 States, the District of Columbia, and the territories had approved SCHIP State plans, 17 Medicaid expansions, 18 separate SCHIPs, and 21 programs that are combination plans. In addition, as of August 2005, CMS has reviewed and approved over 200 SCHIP State plan amendments and 16 section 1115 waivers. Of the 16 section 1115 waivers approved, 12 were waivers of title XXI for Separate Child Health Programs, and 4 were waivers of title XIX for Medicaid Expansion Programs.

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

### Other Activities

In addition to making health care payments to providers and the States on behalf of our beneficiaries, CMS makes other important contributions to the delivery of health care in the U.S.

#### ***Survey and Certification Program***

We are responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, training inspectors, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in over 251,000 medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, and end stage renal disease facilities.

#### ***Clinical Laboratory Improvement Amendments Program (CLIA)***

The CLIA expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing specimens from the human body for health purposes. We regulate all laboratory testing (whether provided to beneficiaries of CMS programs or to others) including those performed in physicians' offices. In partnership with the States, we certify and inspect more than 12,000 laboratories each year. Data from these inspections reflect significant improvements in quality of testing over time. The CLIA program is a 100 percent user-fee financed program. The CLIA program is jointly administered by three HHS components: (1) CMS manages the financial aspects of the program, contracts and trains State surveyors to inspect labs, and oversees program administration, (2) the Centers for Disease Control and Prevention (CDC) provides research and technical support, and (3) the FDA performs test categorization.

#### ***Health Care Quality Improvement***

The CMS continues its leadership as a public health agency with priorities centered on improving quality of American health care. Unlike any time in the agency's history, all Americans—not just Medicare beneficiaries—can better compare quality and make informed health care decisions with confidence that providers can get access to the information and resources they need to improve.

The CMS' quality agenda, set by its Quality Council, has membership from across the agency and is chaired by the Administrator. The Council has emphasized that transformational or accelerated change is needed; to achieve it, CMS will use partnerships, public reporting, pay for performance, quality education and resources, and the promotion of effective health care technologies.

The CMS' vision for quality improvement is the *right care for every person every time*. To accomplish it, CMS will influence both the health care system and the care that is

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delivered so it can be made safe, effective, timely, patient-centered, efficient, and equitable—the aims that correspond to the Institute of Medicine's (IOM's) *Crossing the Quality Chasm* report.

To achieve these aims, CMS utilizes regulation and enforcement activities, improved consumer information, community-based quality improvement programs, as well as collaboration and partnership. At the core of CMS' resources are its Quality Improvement Organizations (QIOs), Medicare contractors that work to improve quality of care, measure and reduce the incidence of improper FFS inpatient payments, address beneficiary complaints and patterns of potentially substandard care, and offer mediation services to help address poor communication issues between health care providers and patients.



Congress created the QIO Program in 1982 to provide a nationwide network of health care organizations to help practitioners and providers improve. As CMS begins its new three-year contract with the QIOs as stewards of the Medicare trust fund, QIOs are helping providers move toward a more dynamic and evolving public reporting and pay-for-performance quality improvement environment. QIOs, working with providers in four priority settings—hospitals, physician offices, nursing homes, and home health—are helping them employ best practices to eliminate errors and improve quality of care.

In order to ensure value to every taxpayer, CMS' quality agenda is demonstrating improvement in quality measures and achieving a greater degree of improvement among providers who work with QIOs more intensively. QIOs also work on CMS' national agenda for the Government Performance and Results Act (GPRA), with goals that include priorities for improving adult immunization rates and diabetes care, optimizing the timing of antibiotics prior to surgery, and increasing vascular access for hemodialysis patients.

Through innovative partnerships, public reporting and its QIOs, CMS has achieved greater momentum toward IOM's six aims. This year, CMS and its public-private collaboration with the Hospital Quality Alliance (HQA), launched a robust, prioritized, and standardized set of hospital quality measures for use in voluntary public reporting. Medicare beneficiaries, as well as all consumers, can access *Hospital Compare*, a web tool that provides valid, credible, and user-friendly information about the quality of care delivered in the Nation's hospitals. To date, more than 90 percent of approximately 4,000 participating U.S. hospitals are reporting at least the 10 clinical "starter" measures. For 2006, approximately 96 percent of the hospitals that submitted data will meet the criteria and are eligible to receive incentive payments.

The CMS also added new surgical infection prevention measures and a new pneumonia measure to *Hospital Compare*, bringing the total number of measures to 20. The two new surgical infection prevention measures are the first of a larger set of patient safety measures that will be collected as part of the Surgical Care Improvement Project (SCIP). The CMS is one of 10 national organizations spearheading this public and private-sector partnership, which has the goal of improving patient safety and reducing the incidence of postoperative complications by 25 percent in U.S. hospitals by the year 2010. In addition to improving surgical care, QIOs are working to continue quality improvement around other care measures for hospital patients, including rural settings, and are collecting and reporting quality performance data for a better informed public.

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The CMS is challenging its contractors to achieve greater impact than before and continues to place similar demands on itself. Recent examples are through its breakthrough initiatives, where CMS initiated innovative partnerships bringing diverse organizations and stakeholders together to achieve goals and positive change in less time. Medicare's most vulnerable population, kidney dialysis patients, stand to benefit from the first breakthrough to improve the use of fistulas as their form of vascular access for dialysis. Fistula First breakthrough is a key component of Medicare's ESRD Quality Initiative.

ESRD is Medicare's only disease-specific program that entitles people of all ages to Medicare coverage on the basis of their diagnosis. The objective of the ESRD Quality Initiative is to stimulate and support significant improvement in the quality of dialysis care. Through partnerships as well as contracts with its 18 ESRD Networks, CMS is collaborating with dialysis providers, primary care physicians, nephrologists, and others to promote the need to double the percentage of patients with fistulas over the next five years.

Another breakthrough priority for CMS is its requirement for nursing homes to vaccinate residents against influenza and pneumococcal disease. CMS has created new conditions and incentives for nursing homes, including increasing the average Medicare payment rate for administering each shot. The CMS also increased inspections and strengthened standards to increase fire safety in nursing homes. To further efforts in reducing the use of physical restraints and the prevalence of pressure ulcers, CMS formed an internal Long-Term Care Task Force and prepared an action plan to promote the effort. Nursing homes, working intensely with QIOs, continue to make significant improvements by reducing both the prevalence of pain in every State in the country and the use of restraints in most.

In physician offices, QIOs are moving the CMS quality agenda through their work with doctors to help create systems that better match an individual patient's needs by using technology to track patient histories and treatments. The Doctor's Office Quality Improvement Technology (DOQ-IT) project will support physician offices to transform care, improve the management of chronic diseases, and improve preventive healthcare services, such as cancer screening and adult immunizations by reducing human error and automatically identifying risk factors.

Cultural competency education and technical assistance to physician offices are also part of CMS' quality improvement aim for identifying and addressing unique racial and/or ethnic factors that contribute to an underserved population's disparate burden of disease and disability. QIOs are working to improve performance measure results among underserved populations in the clinical areas of breast cancer, adult immunizations, and diabetes.

In the home health care setting, patients are recovering faster and with less chance of re-hospitalization, a priority focus for QIOs in working with home health agencies under the new CMS contract. QIOs are helping home health agencies improve performance measures on CMS' *Home Health Compare* and implement telehealth technology—such as video and phone monitoring, or direct access to the information on a monitoring machine in a patient's home.

### **Coverage Policy**

Coverage policy affects every insurer and health care purchaser in today's health care market. The CMS has established a process that provides current information on coverage issues on the CMS coverage web site and also facilitates input from all stakeholders,

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including beneficiaries and health care experts, through the two public comment processes that occur for every National Coverage Determination. The CMS also involves the public through its Medicare Coverage Advisory Committee (MCAC). The MCAC is comprised of a panel of consumer, industry, and patient advocate members; moreover, each of the 5 to 6 meetings held each year include opportunities for the general public to participate. We also rely on state-of-the-art technology assessment and support from other Federal agencies, as well as considerable staff expertise.

Medicare is a leader in evidence-based decision making for coverage policy. Our own extensive payment data contain additional useful information that is used by the Agency for Healthcare Research and Quality and others for assessing the effectiveness of a variety of medical treatments.

### ***Insurance Oversight and Data Standards***

The CMS has primary responsibility for implementing and enforcing Federal standards for the Medigap insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. We work with the State Insurance Commissioners' offices to ensure that suspected violations of Federal laws governing the marketing and sales of Medigap are addressed.

We are responsible for implementing and enforcing most of the HIPAA title II administrative simplification provisions, which are aimed at streamlining healthcare administration and at reducing administrative costs. Title II of HIPAA requires HHS to adopt national uniform standards for the electronic transmission of certain health information. As a result, "covered entities" such as health care providers, health plans, billing services, and other business partners, who do business electronically, must use the same health care transactions, code sets, and identifiers. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any electronic transmission of specified transactions, including claims payment, remittance advice, and coordination of benefits. Title II of HIPAA also requires that patients' personal health information must be more securely guarded and more carefully handled while it is being used by health care providers and health plans. In response, CMS issued a regulation outlining the administrative, technical, and physical safeguards required to protect confidentiality, integrity, and access of protected health care information. We are also responsible for implementing HIPAA's requirements for health care providers, health plans, and employers to have standard identifiers for use on standard transactions.

As a result of the insurance reform provisions of HIPAA title I, CMS has a role in relation to State regulation of health insurance coverage that is similar to its Medigap oversight responsibilities. We work with the State Insurance Commissioners' offices, the U.S. Department of Labor, and the Internal Revenue Service (IRS) to implement these provisions. The common goal is to improve access to health coverage for individuals who move from job to job, or who lose their group health coverage and must purchase individual coverage.

The CMS also has *advisory* jurisdiction with respect to the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage as it pertains to State and local governmental employers and the group health plans that they sponsor. (Title XXII of the Public Health Service Act; 42 U.S.C. 300bb-1 through 300bb-8.) While there is no Federal administrative enforcement authority under the public sector COBRA statute, the

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law affords individuals a private cause of action for equitable relief with respect to a failure of a state, political subdivision, or agency or instrumentality of either, to comply with public sector COBRA requirements.

### **PERFORMANCE GOALS**

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GPRA mandates that agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs. The CMS has embraced that charge and has emphasized the themes of accountability, stewardship, and a renewed focus on the customer with its strategic and annual goals and its mission to “assure health care security for beneficiaries.”

The CMS' approach to performance measurement under GPRA is to develop goals that are representative of our vast responsibilities. The CMS performance budget describes its performance goals and their linkage to long-term strategic goals, while also complementing and supporting the CMS budget submission. The performance budget includes the steps to accomplish each performance goal, and establishes a method and data source for measuring and reporting. The CMS uses performance information to identify opportunities for improvement and to shape its programs.

The CMS annual performance goals also reinforce the President's Management Agenda (PMA). For example, the PMA objective to improve financial performance is reflected by the goal to reduce the percentage of improper payments made under the Medicare FFS program. Performance goals are also key to the Office of Management & Budget's Program Assessment Rating Tool (PART) and support the PMA objective of integrating budget and performance.

The FY 2005 performance budget includes 32 goals for CMS programs, highlighting major program areas and budget categories. The performance budget does not reflect every activity and challenge encountered by the Agency. Instead, it reflects key Administration and CMS priorities that are representative of the vital activities CMS performs to fulfill its mission. The performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination as well as sound business sense.

Some of CMS' key FY 2005 performance goals and outcomes are highlighted below. The progress on the remaining goals will be submitted with the Annual Performance Report included in the FY 2007 President's budget request.

### **Implement the New Medicare-Endorsed Prescription Drug Card**

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The CMS FY 2005 target was to monitor whether CMS is meeting the informational needs of people with Medicare regarding the prescription drug card program. This includes, for example, monitoring questions that come into the 1-800-MEDICARE call center to ensure customer service representatives have the information needed to

## **CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005**

answer specific questions. The CMS also provided information through written materials and the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

The MMA provides Medicare beneficiaries access to prescription drug coverage and the buying power to reduce the prices they pay for drugs. The MMA provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all people with Medicare.

People with Medicare without drug coverage are now eligible for the Medicare-endorsed Prescription Drug Discount Card, which began June 1, 2004, six months after MMA was enacted. The Medicare-endorsed Prescription Drug Discount Card will continue until the full benefit is implemented in January 2006. The card program is estimated to save beneficiaries between 10 percent to 25 percent on most drugs.

Since early June 2004, there has been steady growth in beneficiaries signing up for the card. To date, over 6 million beneficiaries have enrolled. This target was met for FY 2005 and will be discontinued in the future.

### **Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive**

A fundamental CMS goal is to assure satisfaction in the Medicare-related experiences of its beneficiaries. To determine beneficiary satisfaction for the FY 2005 performance goal, CMS used the access to care for illness and injury and access to specialist measures as recorded in the Consumer Assessment of Health Plans Surveys (CAHPS). The targets for managed care (MC) access to care and access to specialist were 93 percent and 86 percent, respectively; and for FFS access to care and access to specialist, they were 95 percent and 85 percent, respectively. This goal has a five-year measurement period to allow for the generation of significant statistical data to assess beneficiary satisfaction.

The CMS forwards CAHPS annually to representative samples of beneficiaries enrolled in each Medicare MC plan as well as those enrolled in the original Medicare FFS plan. The CMS provides comparable sets of specific performance measures collected in CAHPS to QIOs at the annual American Health Quality Association meeting. In addition, this information is provided to health plans and beneficiaries through various means, including the National *Medicare & You* Education Program (NMEP). Final FY 2005 data will be available the summer of 2006.

### **Protect the Health of Medicare Beneficiaries Age 65 and Older by Increasing the Percentage of those who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal**

Under the QIO program, CMS maintains contracts with independent physician organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. The QIO responsibilities are specifically

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defined in the portion of the contract called the Statement of Work (SOW). Each SOW is three years in duration and may vary the activities the QIOs perform. The QIO program is funded directly from the Medicare trust funds.

One of the performance goals representing the QIO program is to increase the percentage of those Medicare beneficiaries age 65 years and older who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal as recommended by the Advisory Committee on Immunization Practices (ACIP) and other leading authorities. The CMS FY 2005 targets were 72.5 percent for influenza and 69 percent for pneumococcal. Final FY 2005 data will be available December 2006. We are currently awaiting final data on the FY 2004 targets.



In recent years, there have been influenza vaccine shortages and distribution delays which have impacted the delivery of immunizations. In October 2004, just as influenza immunization was beginning, one of the two influenza vaccine manufacturers producing inactivated influenza vaccine for the United States announced that, due to quality issues, none of its vaccine supply would be available. Loss of this anticipated vaccine drastically reduced the Nation's influenza vaccine supply.

In addition to supply and distribution challenges, there have been provider concerns about reimbursement rates, which CMS continues to address. Beginning in 2005, physicians were paid for injections and vaccinations even when performed on the same day as other Medicare-covered services. This was not previously covered. The "Welcome to Medicare" effort, which began in 2005, addresses immunizations. Based on recent challenges concerning influenza vaccine supply and distribution, CMS is changing the influenza focus in its FY 2006 and FY 2007 goals to nursing homes where it may have greater impact. However, CMS' pneumococcal targets remain unchanged.

### **Decrease the Number of Uninsured Children by Working with the States to Enroll Children in SCHIP and Medicaid**

The CMS FY 2005 target was to increase the enrollment of children in SCHIP and Medicaid by 3 percent, or approximately one million, over the FY 2004 level.

Through title XXI of the Social Security Act, the states were given the option to expand their Medicaid program, establish a separate SCHIP, or use a combination of both. The SCHIP and Medicaid programs have enhanced the availability of health care coverage to improve the quality of life for millions of vulnerable, uninsured, low-income children. Consistent with the purpose of the programs, CMS has established this goal to increase the number of children enrolled in SCHIP and Medicaid.

Many states have eliminated barriers that prevent families from enrolling in Medicaid and SCHIP. For example, some states simplified application forms and

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eliminated income verification requirements. The CMS continues to work with the states to assure that their programs are designed to best meet the needs of their children and provides extensive technical assistance to states that need to modify their programs. In addition, CMS published a regulation, which allows states to provide health care coverage under SCHIP to pregnant women for children who are not yet born.

### **Improve the Health Care Quality Across Medicaid and SCHIP**

The CMS believes that performance measurement information can improve service delivery to those individuals served by the Medicaid and SCHIP programs. The CMS and the states are planning a strategy for the coordinated use of performance measures for Medicaid and SCHIP programs for quality improvement in both FFS and managed care delivery systems. The CMS communications with the states indicate that they will be supportive of this position. As CMS and the states proceed to implement this mutually agreed upon strategy, multiple approaches to using performance measures to achieve improvements in health care quality will be identified.

The CMS began working with the states to jointly explore a strategy for state and federal use of performance measures. Seven measures were proposed by a workgroup of State Medicaid and SCHIP officials as performance indicators on which the states would voluntarily report. The proposed measures are: adult access to preventive/ambulatory health services; children's access to primary care practitioners; comprehensive diabetes care; prenatal and postpartum care; use of appropriate medications for children with asthma; well child visits for children in the first 15 months of life; and well child visits in the 3rd, 4th, 5th, and 6th years of life. The CMS met both of the following FY 2005 targets:

*The FY 2005 Medicaid target* was to provide technical assistance to the states in performance measurement calculation and reporting; to collect, on a voluntary basis, 2002 performance measurement data from a minimum of 10 states; and to provide technical assistance to improve state capability for performance measurement calculation and reporting and to encourage voluntary reporting by additional states.

*The FY 2005 SCHIP target* was to continue to collect core performance measurement data from states through the state annual reports; use the new automated system to analyze and evaluate performance data; and to provide technical assistance to states on establishing baselines, measurement methodologies, and targets for SCHIP core measures.

### **Reduce the Percentage of Improper Payments Made Under the Medicare FFS Program**

The CMS is committed to reducing the percentage of improper payments made under the Medicare FFS program. One of CMS' key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers for covered services provided to eligible beneficiaries. Paying claims right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable

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Medicare trust fund dollars. The CMS FY 2005 target for the Medicare FFS error rate was 7.9 percent (gross) with a baseline of 10.1 percent in 2004.

The error rate estimate consists of CMS' two Medicare FFS measurement programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). This year, CMS sampled approximately 143,000 claims for CERT and approximately 41,000 discharges for HPMP. These programs provide CMS with a rigorous set of data that CMS can use to manage Medicare contractors, identify and prevent errors, and educate providers that bill CMS programs.

The CMS analysis for FY 2005 indicates that the gross paid claims error rate is 5.2 percent or \$12.1 billion in gross improper payments.

The CMS did meet its goal for FY 2005. The CMS is continually working with the contractors that pay Medicare claims and the QIOs on aggressive efforts to lower the paid claims error rate, including: (1) developing a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data, (2) increasing and refining one-on-one educational contacts with providers found to be billing in error, (3) developing projects with the QIOs to address state-specific admissions necessity and coding concerns, as well as to facilitate the surveillance and monitoring of inpatient payment error trends by error type, and (4) developing new data analysis procedures to assist CMS in identifying payment aberrancies and use that information in order to stop improper payments before they occur. The CMS has directed Medicare contractors to develop local efforts to lower the error rate by developing plans that address the problems that result in errors. These plans must specify the steps they are taking to fix the problems and other recommendations that will ultimately lower the error rate.

The CERT program is an important tool in monitoring contractor performance. It provides CMS with the fundamental structure to hold the FFS contractors accountable for the services they provide as CMS moves from contracts that simply pay contractors to process Medicare claims to performance-based contracts.

## **FINANCIAL ACCOMPLISHMENTS AND STATEMENT HIGHLIGHTS**

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For the seventh consecutive year, CMS' financial statement auditors have issued an unqualified audit opinion on CMS' financial statements, indicating that the financial statements are fairly presented in all material respects. The strategic vision for financial management at CMS is to develop and maintain a strong financial management operation to meet the changing requirements and challenges of the twenty-first century as we continue to safeguard the assets of the Medicare trust funds. To accomplish this vision,

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CMS implemented many initiatives throughout CMS—although all may not be discussed in detail here. Some of the initiatives were new for FY 2005; some are carry-overs from prior years. However, all of the initiatives set out to improve CMS' financial management and reporting in order to provide timely, reliable, and accurate financial information to allow CMS management and other decision makers to make timely and accurate program and administrative decisions. These initiatives reflect CMS' efforts to consciously address the annual financial statement audits' results and recommendations and make improvements in its operations.

### Healthcare Integrated General Ledger Accounting System

Although the Medicare contractors' claims processing systems are operating effectively in paying claims, they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, they do not meet the provisions of the Federal Financial Management Improvement Act of 1996 (FFMIA). Therefore, a key element of our strategic vision is to acquire a FFMIA-compliant financial management system that will include all Medicare contractors. This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). As part of this effort, CMS will replace the Financial Accounting and Control System (FACS), which accumulates all of CMS financial activities, both programmatic and administrative, in its general ledger.

Following the guidance of the Office of Management and Budget (OMB) Circular A-130, *Management of Federal Information Resources*, CMS acquired a commercial-off-the-shelf (COTS) product for HIGLAS. IBM is the systems integrator, and is providing application service provider services. Oracle Corporation is providing the financial accounting software. Implementing an integrated general ledger program will give CMS enhanced oversight of contractor accounting systems and provide high quality, timely data for decision-making and performance measurement.

The HIGLAS project began with a pilot program with one Medicare contractor (Palmetto Government Benefit Administrators) that processes primarily hospital and other institutional claims, and another Medicare contractor (Empire Blue Cross Blue Shield) that processes primarily physician and supplier claims. The pilot phase resulted in the re-engineering of the accounting business processes of the pilot Medicare contractors to support the accounting software. The pilot phase culminated with the successful production cut-overs at both Palmetto Government Benefit Administrators—Part A in May 2005, and Empire Blue Cross Blue Shield—Part B in July 2005. In addition, two non-pilot Medicare contractors were transitioned to HIGLAS. Empire Blue Cross Blue Shield—Part A went into production August 2005, and First Coast Service Options—Part A went into production September 2005. HIGLAS is now the system of record for these contractor sites. There are two additional Medicare contractors expected to transition to HIGLAS in the near future. One is TrailBlazer Health Enterprises—Part A and, the other is Mutual of Omaha—Part A. The transition of administrative accounting to HIGLAS is in the requirements validation phase. A detailed roll-out schedule is being finalized.

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HIGLAS will not only enable CMS' compliance with FFMIA, the new system will also strengthen management of Medicare accounts receivable and allow more timely and effective collection activities on outstanding debts. These improvements in financial reporting by CMS and its contractors are essential to retaining an unqualified opinion on our financial statements, meeting the requirements of key Federal legislation, and safeguarding government assets.



### **Financial Management and Reporting**

There are several initiatives that fall under this category in order for CMS to achieve accurate and reliable financial management and reporting.

#### ***Communication***

The CMS established the Risk Management and Financial Oversight Committee which holds monthly meetings with designated members of CMS' senior management that have a direct or indirect effect on CMS' financial management processes. The purpose of this committee is three-fold. The committee (1) ensures that any issue causing legal, operational, or financial risk impacting the preparation of accurate and complete financial statements or completion of the CFO audit are discussed and resolved in a timely manner; (2) ensures that detailed corrective action plans addressing all findings from CMS' annual financial statement audit are developed and timely implemented; and (3) assists in the oversight responsibilities for (a) the integrity of the Agency's financial statements, (b) the Agency's compliance with legal and regulatory requirements and (c) the proper functioning of internal controls, including the assessment and documentation of such as outlined in the OMB Circular A-123, Management's Responsibility for Internal Controls. The establishment of this committee ensures effective communication and a coordinated process among cross-functional areas within CMS.

The CMS also enhanced its current procedures for handling correspondence that relates to complaints and allegations about CMS employees or other matters causing legal, operational, or financial risk to CMS. These procedures included developing a process to track and update items referred to the Office of Inspector General (OIG) for follow-up. These procedures were disseminated throughout CMS for immediate implementation during FY 2005.

Additionally during FY 2005, with the assistance of a certified public accounting firm, CMS developed an inter-active training program entitled, "The CMS Financial Management Training Session." All members of CMS management and those considered key individuals that impact financial management, internal controls, and the financial statement audit were required to attend. This training raised CMS management's awareness of strong financial management and internal controls by providing attendees with basic insight and knowledge on financial management, as well as outlining management's responsibilities as stewards of CMS' programs. This training session also

## **CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005**

provided individuals with an understanding of the elements of the Statement of Auditing Standard (SAS) 99 and why it is necessary for the annual financial statement audit.



### ***Financial Reporting***

The CMS enhanced its current framework for financial reporting. Specifically, procedures were developed that require the preparation of “white papers” to ensure that any significant changes/updates to CMS’ accounting and financial reporting policies are properly evaluated by the management in the Office of Financial Management and approved in writing. This new process ensures that changes are implemented in an effective and efficient manner and that changes/updates to the financial statements conform to generally accepted accounting principles.

We continued preparing automated formatted financial statements produced directly from FACS, which includes all financial data, including data provided by Treasury’s Bureau of Public Debt and other Federal agencies. This enabled the system to produce an audit trail documenting manual adjustments made to accounts that affect the financial statements. We also produced interim financial statements for the quarters ending December 31, 2004, March 31, 2005, and June 30, 2005, and submitted our financial statements through the automated financial statement system implemented by HHS.

We have also complied with Treasury’s November 2005 reporting requirements for the Federal Agencies Centralized Trial Balance System (FACTS) I and II. We continued to improve the operation of FACS by programming and implementing numerous accounting enhancements. These changes ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations and controls.

### ***Debt Management***

Through our Medicare contractors, we collect the majority of our debt because most overpayments are recognized timely, thus allowing future claims to be offset against current overpayments. We also pursue recovery of debt through demand letters. Debts that are over 180 days delinquent are subject to the Debt Collection Improvement Act of 1996 (DCIA). Under the DCIA, CMS refers all eligible debts over 180 days delinquent to Treasury—via the HHS Program Support Center (PSC), which serves as the Debt Collection Center (DCC)—for cross-servicing and/or Treasury Offset Program (TOP). Debts referred to TOP are matched to Federal payments for potential offset. Debts referred for cross-servicing, which is the other primary collection tool used by Treasury, can have a variety of collection activities, including sending additional demand letters, referring debts to TOP, referring debts to private collection agencies, negotiating repayment agreements, and referring some debts to the Department of Justice for litigation.

During FY 2005, we referred approximately \$633 million of delinquent debt to Treasury for cross-servicing and TOP. This brought our total gross delinquent debt referred to approximately \$6.8 billion, which is about 98 percent of the total net eligible to be referred.

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### ***Administrative Payments***

We also made important accomplishments in our administrative payment areas. We continued to pay all of our administrative payments on time in accordance with the Prompt Payment Act. Over 96 percent of our vendor reimbursements and virtually 100 percent of our travel reimbursements are made electronically.

### ***Budget Execution***

For FY 2005, CMS' budget execution function continues to be a major strength. The CMS established a Chief Operating Officer who works closely with the Chief Financial Officer to ensure that an operating plan is developed timely and supports CMS' priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that have been approved by the Administrator. The CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated while at the same time meeting reasonable but aggressive lapse targets.

### ***Medicare Secondary Payer (MSP)***

The CMS efforts in the MSP area saved the Medicare trust funds approximately \$4.6 billion through the first 10 months of FY 2005. The CMS continues to expand and improve its coordination of benefits activities to ensure that fewer mistaken payments are made while, at the same time, continuing to actively pursue delinquent debts owed the Medicare program in compliance with DCIA. With the resumption of normal Internal Revenue Service/Social Security Administration/CMS Data Match (DM) operations in FY 2004 through the present, savings attributed to DM increased significantly to \$431 million for the first 10 months of FY 2005. The CMS expects savings attributable to the MSP Program to continue to grow through FY 2006 as improved methods of collecting MSP are expanded.

The CMS continues to pursue Voluntary Data Sharing Agreements (VDSAs) with insurers and large employers to secure health care coverage information on working enrollees and dependents. Currently 101 insurers, large employers, and pharmacy benefit managers have signed VDSAs with CMS. Although CMS suspended the signing of new VDSAs for 6 months while the VDSA process was modified to implement some of the new Medicare Modernization Act (MMA) data collection requirements, interest in the VDSA process is higher than ever. The CMS expects numerous new agreements to be signed over the course of FY 2006 as more employers, insurers, and pharmacy benefit managers take advantage of the VDSA program to coordinate the new MMA drug benefit with Medicare. Overall savings attributed to this program were \$377 million for the first 10 months of FY 2005, which already represents an increase over the \$282 million in savings achieved in FY 2004. The CMS expects savings from the VDSA program to continue to grow in FY 2006 as more new agreements are signed and brought into full production.

In addition, the CMS is continuing with the workers' compensation (WC) DM initiative. This involves entering into data sharing agreements with State WC boards and

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commissions and large WC insurers. The CMS launched this effort in FY 2003 with the signing of the first WC DM agreement with the State of California. The CMS executed agreements with the States of Kansas, Maryland, New York, and Oregon in FY 2004. These agreements have resulted in the creation of many new MSP auxiliary records and represent

\$6.8 million in cost avoided savings to the Medicare program. Agreements with the States of Florida and Texas were finalized this fiscal year. We are in negotiations with the States of New Jersey and Pennsylvania, as well as two large WC insurance firms, and have our first face-to-face meetings scheduled with the States of Michigan, Nebraska, and Wisconsin, in September.



The CMS has a contractor to review Workers' Compensation Set-aside Arrangements (WCMSA). During the first ten months of FY 2005, the contractor has approved WCMSA of approximately \$150 million (payments that Medicare would otherwise have been the primary payer). In FY 2005, CMS invested considerable effort in WC outreach and education for our MSP partners; as a result, an increasing number of WCMSAs are being submitted to CMS for review and approval.

### ***Medicare Integrity Program***

The CMS expanded its program integrity efforts and savings by creating a Los Angeles (LA) Satellite Office to detect and prevent fraud in Southern California, in addition to operating the Miami satellite office. The satellite offices implemented several new fraud and abuse initiatives that have resulted in trust fund savings and recoupments. Some of the initiatives include the Beneficiary Identity Theft program, the Independent Diagnostic Testing Facilities program, the Prosthetics and Orthotics project and the Unique Physician Identification Number (UPIN) project.

### **Managed Care Oversight**

Over the past year, CMS has taken steps to develop and refine the managed care financial management systems and processes. In 2005, CMS released an updated version of the Health Plan Management System (HPMS) Monitoring Module, which contains functionalities to accommodate the reporting of Targeted Appeals Monitoring Strategy (TAMS) outcomes in monitoring visits, provided a new HPMS Monitoring Module Users Guide, as well as included numerous standard module updates. Earlier in 2005, in a collaborative effort with the ROs, CMS performed Continuous Quality Improvement (CQI) assessments in order to determine whether the managed care reviews were timely, accurately completed, and in accordance with established procedures and guidelines. The CQI visits provided the impetus for the development of additional training, updated monitoring guides, and additional standard policies and procedures. Finally, CMS hired a contractor to review the operations of the Division of Enrollment and Payment Operations within the Medicare Plan Accountability Group. This contractor will further develop standardized policies and procedures for use in payment operations for managed care and prescription drugs.

## **CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005**

The CMS has also reduced the number of unsettled managed care cost reports. The total backlog of unsettled managed care cost reports at the close of FY 2005 was 50. Disallowances resulting from FY 2005 settlement activity amounted to about \$24 million. For FY 2005, CMS had a rate of return of 7 to 1. The remaining backlog of unsettled managed care cost reports still represents a challenge to CMS because these cost reports have critical issues that must be resolved with Managed Care Organizations. It is these reports that may eventually need many audit adjustments. Thus, many of the more recent cost reports sent to audit have fewer issues. Also, many of these audited plans have incorporated adjustments from prior audits and will require fewer adjustments.

### **Health Programs Financial Management Systems and Oversight**

The CMS has implemented some initiatives to improve the financial management systems and oversight of the Health Programs. Specifically, CMS is working with HHS to assess the feasibility of implementing the Grants Administration and Tracking & Evaluating System (GATES) for the Medicaid and SCHIP programs. The ultimate goal is for the current Medicaid Budget and Expenditure System (MBES) to electronically interface with GATES which will interface with CMS' accounting system. The CMS also implemented procedures to ensure proper user access to MBES. These procedures included requiring password changes every 60 days and the use of a valid e-mail address to access the system. In addition, CMS is in the process of enhancing its oversight of the internal controls supporting State-based information systems used in processing Medicaid and SCHIP benefits.

To ensure proper oversight of the Health Programs, CMS conducts weekly and monthly teleconferences with the ROs. These teleconferences ensure that there is a continuous process to assess and provide training to the ROs, as well as, address any financial management issues. For example, CMS used these teleconferences during FY 2005 to discuss requirements for work paper preparation to reiterate the written instructions that were provided. Additionally, CMS worked with the ROs to establish a peer and supervisory review process; each RO was provided with this process.

### **Medicare Electronic Data Processing (EDP)**

The CMS has made many improvements in Medicare EDP and is continuing its effort to strengthen the controls over that area. During FY 2005, CMS implemented and developed a robust strategy and project plan to address current audit findings as well as root causes. This strategy and plan included the formation of a program office within CMS' Office of Information Systems to manage corrective actions. To heighten awareness over Medicare EDP, a memorandum was issued to the Medicare contractor community. This memorandum was issued directly to the Medicare contractor Vice-Presidents to establish CMS' expectations and reinforce the importance of addressing and sustaining corrective actions. In addition, CMS has conducted and participated in conferences—both in person and via teleconference—with the Medicare contractors to emphasize best

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

practices to address audit findings and the root causes. This has also included CMS having one-on-one meetings with certain Medicare contractors to discuss how to address audit issues and set specific success criteria for the findings.

The CMS has also developed and reiterated various policies, procedures, and processes. For instance, a ***CMS Guidebook for Audits*** was developed during FY 2005. This guide is intended to aid contractors in understanding and preparing for the various types of audits and reviews which may be performed at a Medicare contractor location. The guide features information on audit steps and procedures, documentation requirements, and required interviews.

### Medicare Contractor Oversight

Medicare contractors administer the day-to-day operations of the Medicare program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, Medicare contractors are required to maintain a vast array of financial data. Due to the materiality of this data, CMS must have assurances as to its validity and accuracy.

For the report on internal control, CMS' financial statement auditors reported that CMS continued to build upon prior efforts to improve its oversight of Medicare contractors and that it should continue to enhance its review of information included in its financial statements. The CMS continued to use independent certified public accountants (CPAs) to review Medicare contractor accounts receivable balances in order to validate the receivable amounts reported to CMS and the adequacy of their internal controls. For FY 2005, the CPAs conducted reviews at 7 Medicare contractors. Additionally, the scope of these reviews included the timely implementation of Medicare contractors' financial management corrective action plans (CAPs).

On a monthly basis, Medicare contractors perform a reconciliation of their Form CMS-1522 Funds Expended Report to their paid claims or system reports. The CMS selected and performed reviews at four Medicare contractor locations during FY 2005 to test compliance with the 1522 reconciliation procedures. Furthermore, Medicare contractors are required to perform trend analysis on a quarterly basis and maintain supporting documentation to ensure that accounts receivable balances reported are reasonable. The CMS continues to enhance its analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses or inappropriate patterns of financial data accumulation.

### Internal Controls

During FY 2005, CMS contracted with CPA firms to conduct SAS 70 internal control reviews of 15 Medicare contractors, two of which received unqualified opinions and the remainder received very few non-material findings. To ensure that the exceptions are properly addressed in a timely manner, the Medicare contractors develop and submit CAPs.

## **CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005**

For FY 2006, CMS will continue to perform these SAS 70 internal control reviews and monitor Medicare contractors' progress for implementing CAPs.

The CMS also requires all Medicare contractors to submit an annual Certification Package on Internal Controls (CPIC). In the CPIC, contractors are required to report their material weaknesses identified during the FY. The CMS requires CAPs for all material weaknesses reported in the CPICs. In FY 2005, CPIC protocol reviews were conducted at 6 Medicare contractors. The CMS also updated manual instructions that provide guidelines and policies to the Medicare contractors to enable them to strengthen their internal control processes.

### ***Corrective Action Plans***



The Medicare contractors are subject to various financial management and EDP audits and reviews performed by the OIG, Government Accountability Office (GAO), independent CPA firms, and CMS staff to provide reasonable assurance that they have developed and implemented sound internal controls. The results of these reviews indicate if the contractors' internal controls are operating as designed and identify existing deficiencies. Audit resolution is a top priority at CMS and correcting these deficiencies is essential to improving financial management. Therefore, Medicare contractors are required to prepare CAPs, which describes activities to correct all identified findings and the timeframes for which they will be implemented. The CAP report consolidates all findings identified and standardizes the format of CAP submissions and facilitates CMS' monitoring responsibilities of these reports. Quarterly updates to the CAPs are required and CMS reviews all CAP submission for adequacy.

The CMS contracted with independent CPA firms to conduct CAP follow-up reviews during the SAS 70 internal control reviews and accounts receivable agreed upon procedure reviews that were performed in FY 2005. The CPA firms were able to verify the successful implementation of 201 Medicare contractor CAPs.

### **Improper Payments**

In 2002, Congress passed the Improper Payment Information Act (IPIA) that aims to standardize the way Federal agencies report improper payments in programs they administer. The IPIA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received. The CMS has begun to implement the requirements of the Improper Payments Information Act of 2002 (IPIA). Although CMS has not fully complied with the OMB's IPIA guidance, CMS has

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

implemented a comprehensive process that measures the payment error rates for the Medicare Fee-for-Service (FFS) program. The CMS has initiatives in place to enhance its program integrity efforts and IPIA compliance to include Medicare managed care, Medicaid, and SCHIP.

### **Medicare**

The identification and reporting of improper payments has been in place for Medicare FFS since FY 1996. A change in methodology required by the IPIA is the use of gross improper payment figures. The gross improper payment figure is calculated by adding together the absolute value of underpayments and overpayments. From FY 1996–FY 2003, CMS reported the Medicare FFS estimate of improper payments as a net number (where underpayments were subtracted from overpayments). The FY 2004 and FY 2005 Medicare FFS estimates comply with the IPIA requirement to report gross numbers.

The FY 2005 paid claims error rate is lower than our 2005 goal of 7.9 percent gross. The CMS analysis for FY 2005 indicated that the paid claims gross error rate was 5.2 percent or \$12.1 billion in gross improper payments. As discussed in the Performance Goals section of this Financial Report, CMS is taking steps to continue to reduce the error rate for the future.

#### **FY 2005 Gross and Net Improper Payments and Error Rates in the Medicare FFS Program**

FY	Overpayments	Underpayments	Gross	
			Improper Payment Amount (Overpayments + Underpayments)	Error Rate
2005	\$11.2 B	\$0.9 B	\$12.1 B	5.2 %

### **Medicare Managed Care**

A key challenge facing CMS in the coming years will be assessing compliance with the IPIA under an expanded Medicare Advantage program. The CMS conducted a risk assessment of the Medicare Advantage program this year and believes the risk to be high and will thus be outlining a strategy for IPIA compliance for FY 2006.

### **Medicaid and SCHIP**

Medicaid and SCHIP payments are susceptible to erroneous payments as well. Thus, the Federal government and the States have a strong financial interest in ensuring that claims are paid accurately. In FY 2000, CMS adopted a GPRA goal to explore the feasibility of developing a methodology to estimate payment accuracy in the Medicaid program. In response to this GPRA goal, CMS initiated the Payment Accuracy Measurement (PAM) Project.

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

In July 2001, CMS solicited the States to participate in the first year of the PAM demonstration project, which was implemented in FY 2002. The project essentially requested that the States develop a methodology to estimate payment accuracy. The results of this pilot project indicated that was feasible to estimate payment accuracy in the Medicaid program. As a result, CMS conducted a second year of the pilot project in FY 2003. Shortly after the beginning of the second year of the PAM project, Congress passed the IPIA.

In FY 2004, CMS continued the third year of the pilot and refined the methodology to include elements that allow for greater compliance with IPIA. For FY 2005, CMS reported FY 2004 payment accuracy rates for Medicaid and SCHIP based on the PAM pilot project operated by volunteer States. The national accuracy rate for Medicaid is 93.96<sup>1</sup> percent and the range of accuracy rates for SCHIP is 74.85 percent–99.52 percent for FFS and 80.39 percent–100 percent for managed care. The CMS reported a range of accuracy rates for SCHIP rather than a national rate because only 15 States volunteered to measure SCHIP payment accuracy for the pilot project.

In FY 2005, CMS provided enhanced guidance to States for purposes of consistency in applying the methodology. The methodology has been designed to measure payment error in Medicaid and SCHIP in both the FFS and managed care components of these programs.



The CMS is currently developing a national contracting strategy that will measure the FFS, managed care and eligibility components of Medicaid and SCHIP each year and report those rates to OMB for inclusion in the Performance and Accountability Report (PAR). The national contracting strategy includes recommendations made by States and other interested parties in commenting on the proposed rule that CMS published August 27, 2004, (to require all 50 States and the District of Columbia to annually estimate payment errors in their Medicaid and SCHIP programs). The CMS recently issued an interim final rule that responds to the proposed rule, sets forth the national contracting strategy, and invites further comments. The CMS also published an information collection package in the Federal Register on July 22, 2005, that invited comments on State submittal of claims data and other information necessary for the Federal contractor(s) to measure Medicaid FFS error rates. The CMS is planning to measure a Medicaid FFS error rate in FY 2006.

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<sup>1</sup> This error rate is not statistically valid and should not be compared to future statistically valid error rates. Reasons why this error rate is not valid include: the sampled states were self-selected (e.g., volunteers) versus being randomly selected; states used different methodologies to review beneficiary eligibility; and some states reviewed a different number of cases for eligibility than others. For example, Arizona reviewed all claims for beneficiary eligibility. Therefore, the eligibility errors found by Arizona had a greater effect on the national estimate than the other state's eligibility errors.

### Financial Statement Highlights

#### ***Consolidated Balance Sheet***

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). The CMS' Consolidated Balance Sheet shows \$340.6 billion in assets. The bulk of these assets are in the Trust Fund Investments totaling \$298.4 billion, which are invested in U.S.



Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The next largest asset is the Fund Balance with Treasury of \$20.8 billion, most of which is for Medicaid and SCHIP. Liabilities of \$56.5 billion consist primarily of the Entitlement Benefits Due and Payable of \$53.8 billion. The CMS net position totals \$284.1 billion and reflects the cumulative results of the Medicare Trust Fund Investments and the unexpended balance for SCHIP.

#### ***Consolidated Statement of Net Cost***

The Consolidated Statement of Net Cost shows a single amount—the actual net cost of CMS operations for the fiscal year by program. The three major programs that CMS administers are Medicare, Medicaid, and SCHIP. The majority of CMS expenses are allocated to these programs.

Total Benefit Payments were \$517.8 billion for FY 2005. Administrative Expenses were \$2.9 billion, less than 1 percent of total net Program/Activity Costs of \$483.4 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was \$295.7 billion. The HI total costs of \$182.7 billion were offset by \$2.3 billion in premiums. The SMI total costs of \$151.3 billion were offset by premiums of \$35.9 billion. Medicaid total costs of \$182.2 billion represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. The SCHIP total costs were \$5.1 billion.

#### ***Consolidated Statement of Changes in Net Position***

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. The line, Appropriations Used, represents the Medicaid appropriations used of \$181.6 billion, \$124.6 billion in transfers from Payments to Health Care Trust Funds to HI and SMI, SCHIP appropriations of \$5.1 billion, and Ticket to Work appropriations of \$324 million. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

Self-Employment Contribution Act (SECA) for the HI trust fund totaling \$169 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of \$113.5 billion, which matches monthly premiums paid by beneficiaries.



### ***Combined Statement of Budgetary Resources***

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources, as well as their status at the end of the year. The CMS total budgetary resources were \$670.5 billion. Obligations of \$667.4 billion leave unobligated balances of \$3.1 billion (of which \$451 million is not available). Total outlays, net of collections, were \$650 billion. When offset by \$165.7 billion relating to collection of premiums and general fund transfers from the Payments to Health Care Trust Funds as well as refunds of Medicare contractor overpayments, the net outlays were \$484.3 billion.

### ***Consolidated Statement of Financing***

The Consolidated Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS' general ledger, which supports the Report on Budget Execution and Budgetary Resources (SF 133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost, and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Consolidated Statement of Financing.

### ***Required Supplementary Stewardship Information (RSSI)***

As required by the Statement of Federal Financial Accounting Standards (SFFAS) Number 17, CMS has included information about the Medicare trust funds—HI and SMI. The RSSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

### ***Limitations of the Financial Statements***

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990 (P.L. 101-576).

## CMS MANAGEMENT'S DISCUSSION AND ANALYSIS FY 2005

While these financial statements have been prepared from CMS' general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with accounting principles generally accepted in the U.S. for Federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that are prepared from the same books and records. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the ***Budget of the U.S. Government*** and the annual report of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal control rests with CMS management.

The Required Supplementary Information and Required Supplementary Stewardship Information sections are unique to Federal financial reporting. These sections are required under OMB Bulletin 01-09 and are unaudited.

# Principal Statements and Notes

## CONSOLIDATED BALANCE SHEET As of September 30, 2005 and 2004 (in millions)

	FY 2005 Consolidated Totals	FY 2004 Consolidated Totals
<b>ASSETS</b>		
<b>Intragovernmental Assets:</b>		
Fund Balance with Treasury (Note 2)	\$20,789	\$26,570
Trust Fund Investments (Note 3)	298,444	285,792
Accounts Receivable, Net (Note 4)	454	421
Other Assets: (Note 5)		
Anticipated Congressional Appropriation	14,272	9,248
Other		1
<b>Total Intragovernmental Assets</b>	<b>333,959</b>	<b>322,032</b>
Cash and Other Monetary Assets	204	460
Accounts Receivable, Net (Note 6)	1,884	1,905
General Property, Plant and Equipment, Net	392	120
Other (Note 5)	4,201	101
<b>TOTAL ASSETS</b>	<b>\$340,640</b>	<b>\$324,618</b>
<b>LIABILITIES (Note 9)</b>		
<b>Intragovernmental Liabilities:</b>		
Accounts Payable	\$324	\$624
Accrued Payroll and Benefits	4	3
Other Intragovernmental Liabilities (Note 7)	433	344
<b>Total Intragovernmental Liabilities</b>	<b>761</b>	<b>971</b>
Federal Employee and Veterans' Benefits	10	10
Entitlement Benefits Due and Payable (Note 8)	53,754	49,229
Accrued Payroll and Benefits	54	51
Other Liabilities (Note 7)	1,926	2,104
<b>TOTAL LIABILITIES</b>	<b>56,505</b>	<b>52,365</b>
<b>NET POSITION</b>		
Unexpended Appropriations	14,706	16,422
Cumulative Results of Operations	269,429	255,831
<b>TOTAL NET POSITION</b>	<b>\$284,135</b>	<b>\$272,253</b>
<b>TOTAL LIABILITIES AND NET POSITION</b>	<b>\$340,640</b>	<b>\$324,618</b>

The accompanying notes are an integral part of these statements.

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### CONSOLIDATED STATEMENT OF NET COST For the Years Ended September 30, 2005 and 2004 (in millions)

	FY 2005 Consolidated Totals	FY 2004 Consolidated Totals
<b>NET PROGRAM/ACTIVITY COSTS</b>		
<b>GPRA Programs</b>		
Medicare	\$295,713	\$269,748
Medicaid	182,226	177,060
SCHIP	5,135	4,611
<b>Net Cost - GPRA Programs</b>	<b>483,074</b>	<b>451,419</b>
<b>Other Activities</b>		
CLIA	3	4
Ticket to Work Incentive	325	34
<b>Net Cost - Other Activities</b>	<b>328</b>	<b>38</b>
<b>NET COST OF OPERATIONS</b> (Note 10)	<b>\$483,402</b>	<b>\$451,457</b>

The accompanying notes are an integral part of these statements.

### CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION For the Years Ended September 30, 2005 and 2004 (in millions)

	FY 2005 Cumulative Results of Operations	FY 2005 Unexpended Appropriations	FY 2004 Cumulative Results of Operations	FY 2004 Unexpended Appropriations
<b>BEGINNING BALANCES</b>	<b>\$255,831</b>	<b>\$16,422</b>	<b>\$252,558</b>	<b>\$13,441</b>
<b>Budgetary Financing Sources:</b>				
Appropriations Received		311,039		292,330
Appropriations Transferred-out		(1,397)		(1,208)
Other Adjustments (Note 11)		316		(2,637)
Appropriations Used	311,674	(311,674)	285,504	(285,504)
Nonexchange Revenue (Note 12)	185,793		170,377	
Transfers-out				
Without Reimbursement (Note 13)	(502)		(1,183)	
<b>Other Financing Sources:</b>				
Transfers-in/out Without Reimbursement	1		(1)	
Imputed Financing from Costs Absorbed by Others	34		33	
<b>TOTAL FINANCING SOURCES</b>	<b>497,000</b>	<b>(1,716)</b>	<b>454,730</b>	<b>2,981</b>
<b>NET COST OF OPERATIONS</b>	<b>483,402</b>		<b>451,457</b>	
<b>NET CHANGE</b>	<b>13,598</b>	<b>(1,716)</b>	<b>3,273</b>	<b>2,981</b>
<b>ENDING BALANCES</b>	<b>\$269,429</b>	<b>\$14,706</b>	<b>\$255,831</b>	<b>\$16,422</b>

The accompanying notes are an integral part of these statements.

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### COMBINED STATEMENT OF BUDGETARY RESOURCES For the Years Ended September 30, 2005 and 2004

(in millions)

	FY 2005 Combined Totals	FY 2004 Combined Totals
<b>Budgetary Resources:</b>		
Budget authority:		
Appropriations received	\$663,101	\$599,973
Net transfers	(1,397)	(1,208)
Unobligated balance:		
Beginning of period	11,176	511
Spending authority from offsetting collections:		
Earned:		
Collected	78	71
Change in unfilled customer orders:		
Without advance from Federal sources	(2)	3
Transfers from trust funds	2,920	3,758
<b>SUBTOTAL</b>	<b>2,996</b>	<b>3,832</b>
Recoveries of prior year obligations	10,557	9,447
Temporarily not available pursuant to Public Law	(11,150)	(3,921)
Permanently not available	(4,766)	(55)
<b>TOTAL BUDGETARY RESOURCES</b>	<b>\$670,517</b>	<b>\$608,579</b>
<b>Status of Budgetary Resources:</b>		
Obligations incurred: <i>(Note 14)</i>		
Direct	\$667,338	\$597,329
Reimbursable	81	74
<b>SUBTOTAL</b>	<b>667,419</b>	<b>597,403</b>
Unobligated balance:		
Apportioned	2,647	10,356
Unobligated balance not available	451	820
<b>TOTAL STATUS OF BUDGETARY RESOURCES</b>	<b>\$670,517</b>	<b>\$608,579</b>
<b>Relationship of Obligations to Outlays:</b>		
Obligated balance, net, beginning of period	\$50,324	\$51,286
Obligated balance, net, end of period:		
Accounts receivable	(1,624)	(1,691)
Unfilled customer orders from Federal sources	(7)	(8)
Undelivered orders	9,503	10,455
Accounts payable	46,292	41,568
Outlays:		
Disbursements	653,091	588,409
Collections	(3,065)	(3,323)
<b>SUBTOTAL</b>	<b>650,026</b>	<b>585,086</b>
<b>LESS: OFFSETTING RECEIPTS</b>	<b>165,730</b>	<b>136,625</b>
<b>NET OUTLAYS</b>	<b>\$484,296</b>	<b>\$448,461</b>

The accompanying notes are an integral part of these statements.

# CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

## CONSOLIDATED STATEMENT OF FINANCING For the Years Ended September 30, 2005 and 2004 (in millions)

	FY 2005 Consolidated Totals	FY 2004 Consolidated Totals
<b>RESOURCES USED TO FINANCE ACTIVITIES:</b>		
<b>Budgetary Resources Obligated:</b>		
Obligations incurred	\$667,419	\$597,403
Less: Spending authority from offsetting collections and recoveries	13,553	13,279
Obligations net of offsetting collections and recoveries	653,866	584,124
Less: Offsetting receipts	165,730	136,625
<b>NET OBLIGATIONS</b>	<b>488,136</b>	<b>447,499</b>
<b>Other Resources:</b>		
Transfers in/out without reimbursement	1	(1)
Imputed financing from costs absorbed by others	34	33
<b>NET OTHER RESOURCES USED TO FINANCE ACTIVITIES</b>	<b>35</b>	<b>32</b>
<b>TOTAL RESOURCES USED TO FINANCE ACTIVITIES</b>	<b>\$488,171</b>	<b>\$447,531</b>
<b>RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS:</b>		
Change in budgetary resources obligated for goods, services and benefits ordered but not yet provided	\$3,153	\$(1,364)
Resources that fund expenses recognized in prior periods	15,684	12,368
Resources that finance the acquisition of assets	319	112
Other resources or adjustments to net obligated resources that do not affect net cost of operations	502	3,711
<b>TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS</b>	<b>19,658</b>	<b>14,827</b>
<b>TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS</b>	<b>\$468,513</b>	<b>\$432,704</b>
<b>COMPONENTS OF THE NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:</b>		
<b>Components Requiring or Generating Resources in Future Periods:</b>		
Accrued Entitlement Benefit Costs	\$9,470	\$10,039
Liability for Unmatched SMI Premiums (Note 5)	5,173	5,645
Increase in annual leave liability	2	1
Decrease in receivables from the public	693	2,473
Other (Note 7)	(219)	1,866
<b>TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS</b>	<b>15,119</b>	<b>20,024</b>
<b>Components Not Requiring or Generating Resources:</b>		
Depreciation and amortization	48	5
Other	(278)	(1,276)
<b>TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES</b>	<b>(230)</b>	<b>(1,271)</b>
<b>TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD</b>	<b>14,889</b>	<b>18,753</b>
<b>NET COST OF OPERATIONS</b>	<b>\$483,402</b>	<b>\$451,457</b>

The accompanying notes are an integral part of these statements.

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### NOTE 1:

### SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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#### Reporting Entity

The CMS is a separate financial reporting entity of HHS. The financial statements have been prepared to report the financial position and results of operations of CMS, as required by the Chief Financial Officers Act of 1990. The statements were prepared from CMS' accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Circular A-136, **Financial Reporting Requirements**.

The financial statements cover all the programs administered by CMS. The programs administered by CMS are shown in two categories, Medicare and Health. The Medicare programs include:

#### **Medicare Hospital Insurance (HI) Trust Fund**

Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. The CMS payments to managed care plans are also charged to this fund based on an estimate of total spending for HI activity. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). This trust fund has permanent indefinite authority.

#### **Medicare Supplementary Medical Insurance (SMI) Trust Fund**

Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The CMS payments to managed care plans are also charged to this fund based on an estimate of total spending for SMI activity. The financial statements include

SMI trust fund activities administered by Treasury. This trust fund has permanent indefinite authority.

#### **Medicare Prescription Drug Discount Card and Transitional Assistance**

The Medicare Prescription Drug Discount Card and Transitional Assistance Program was enacted into law in December 2003 as part of the Medicare Modernization Act of 2003. The Drug Discount Card program enables Medicare beneficiaries to obtain discounts of 10 to 25 percent on prescription drugs. Medicare also provided a \$600 credit for the purchase of prescription drugs in 2004 and up to an additional \$600 credit in 2005 to people with incomes that are not more than 135 percent of the poverty line if they do not have certain other drug coverage. This program is not intended to be a prescription drug benefit, but rather a measure to help people until the drug benefit is implemented on January 1, 2006.

#### **Medicare Integrity Program (MIP)**

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the MIP and codified the program integrity activities previously known as "payment safeguards." This program is also called the Health Care Fraud and Abuse Control (HCFAC) Program, or simply "Fraud and Abuse." The CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI trust fund.

#### **Payments to the Health Care Trust Funds Appropriation**

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of CMS' admin-

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

istrative costs. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

### ***Permanent Appropriations***

A transfer of general funds to the HI trust fund in amounts equal to Self-Employment Contribution Act (SECA) tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries is made through 75X0513 and 75X0585, respectively. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 2005 are adjustments for late or amended tax returns. The Social Security Amendments of 1994, provided for additional tax payments from Social Security and Tier 1 Railroad Retirement beneficiaries.

The Health programs include:

### ***Medicaid***

Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the CMS share of States' Medicaid costs. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

### ***The State Children's Health Insurance Program (SCHIP)***

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this new insurance coverage. The grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to fund SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved

expenses reported for the period and the grant awards previously issued.

### ***The Ticket to Work and Work Incentives Improvement Program***

The Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, established two grant programs. The Act provides funding for Medicaid infrastructure grants to support the design, establishment and operation of State infrastructures to help working people with disabilities purchase health coverage through Medicaid. The Act also provides funding for States to establish Demonstrations to Maintain Independence and Employment, which provide Medicaid benefits and services to working individuals who have a condition that, without medical assistance, will result in disability.

### ***Program Management User Fees: Medicare Advantage, Clinical Laboratory Improvement Program, and Other User Fees***

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program, now known as the Medicare Advantage program under the MMA, that requires managed care plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. The CMS and the Public Health Service share responsibility for the CLIA program, with CMS having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

### ***Program Management Appropriation***

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs (see Note 13). User fees collected from managed care plans seeking Federal qualification and funds received from other federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated among all programs based on the CMS cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statement of Net Cost in the Supplementary Information section.

### ***Basis of Presentation***

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P.L. 101-576), as amended by the Government Management Reform Act of 1994.

These financial statements have been prepared from the CMS general ledger in accordance with accounting principles generally accepted in the U.S. and the formats prescribed by the OMB Circular A-136. Some amounts shown will differ from those in other financial documents, such as the ***Budget of the U.S. Government*** and the annual report of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

### ***Basis of Accounting***

The CMS uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS. The financial statements are prepared on an accrual basis. Individual accounting transactions are recorded using both the accrual basis and cash basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlaid. The CMS follows standard budgetary accounting principles that facilitate compliance with legal constraints and controls over the use of Federal funds.

The CMS uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate

the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

The CMS uses the cash basis of accounting in the Medicaid and SCHIP programs to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to CMS as of the end of the fiscal year.

### ***Balance Sheet***

The Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). The major components are described below.

#### ***Assets***

**Fund Balances** are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. The CMS also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.

**Trust Fund Investments** are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

**Accounts Receivable, Net** consist of amounts owed to CMS by other Federal agencies and the public. Amounts due are presented net of an allowance for uncollectible accounts.

#### ***Medicare Secondary Payer (MSP)***

**Accounts Receivable (A/R)** consists of amounts owed to Medicare by insurance companies, employers, beneficiaries, and/or providers for payments made by Medicare that should have been paid by the primary

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payer. Receipts are transferred to the HI or SMI trust fund upon collection. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

**Medicare Non-MSP A/R** consists of amounts owed to Medicare by medical providers and others because Medicare made payments that were not due, for example, excess payments that were determined to have been made once provider cost reports were audited. Non-MSP A/R represent entity receivables and, once collected, are transferred to the HI or SMI trust fund. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

**Cash and Other Monetary Assets** are the total amount of time account balances at the Medicare contractor commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

**General Property, Plant and Equipment (PP&E)** are recorded at full cost of purchase, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, net of accumulated depreciation. All PP&E with an initial acquisition cost of \$25,000 or more and an estimated useful life of 2 years or greater is capitalized. The PP&E is depreciated on a straight-line basis over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

In accordance with Statement of Federal Financial Accounting Standards No. 10, Accounting for Internal Use Software, CMS implemented the HHS-wide policy which requires internal use software be capitalized using a threshold of \$1 million, and an estimated useful life of not less than two and no more than five years, except for the Healthcare Integrated General Ledger Accounting System (HIGLAS) as discussed below. Capitalized costs include all direct and indirect costs and are

amortized using the straight-line method. In accordance with HHS policy, enhancements to existing internal use software are capitalized when the life cycle costs of the development stage are \$1 million or more, and they result in significant additional capabilities.

In FY 2001 the CMS began the HIGLAS project to replace the Medicare contractors' and CMS' current accounting systems with a single, unified system. HIGLAS will eventually replace the different systems now in use by contractors that process and pay claims, in addition to CMS' current main-frame-based administrative accounting financial system. In FY 2005, CMS began amortizing HIGLAS over 10 years using the straight-line method in accordance with HHS policy for its unified financial management system.

The General Services Administration (GSA), which charges rent based on commercial rental rates for similar properties, provides the majority of space and property that CMS occupies. Therefore, the cost of GSA owned properties is not recorded in CMS' financial statements.

### Liabilities

**Liabilities** represent amounts owed by CMS. A liability for Federal accounting purposes is a probable and measurable future outflow or other sacrifice of resources as a result of past transactions or events. Since CMS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund.

Liabilities covered by available budgetary resources include (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. The CMS recognizes such liabilities for employee annual leave earned but not taken, amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments, contingent legal liabilities, and for portions of the Entitlement Benefits Due and Payable liability for which no obligations have

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been incurred. For CMS revolving funds, all liabilities are funded as they occur.

**Accounts Payable** consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

**Federal Employee and Veterans' Benefits** consist of the actuarially-determined estimate of future benefits earned by Federal employees and Veterans, but not yet due and payable. These costs include pensions, other retirement benefits, and other post-employment benefits. These benefits programs are normally administered by the Office of Personnel Management (OPM) and not by CMS.

**Entitlement Benefits Due and Payable** represents the liability for Medicare and Medicaid medical services incurred but not paid as of September 30. The Medicare liability is developed by the Office of the Actuary (OACT) and includes (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in FY 2005 but paid in FY 2006, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers. The managed care liability includes amounts incurred related to risk adjustments and other estimates.

The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. The FY 2005 estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

**Accrued Payroll and Benefits** consist of salaries, wages, leave, and benefits earned by employees, but not disbursed as of September 30. Annual leave is accrued as earned and reduced as used. The balances of accrued annual leave and credit leave are analyzed and adjusted to reflect current pay rates. Sick leave and other types of nonvested leave are expensed as taken but not accrued when earned.

**Contingencies** are an existing condition, situation, or set of circumstances involving uncertainty as to

possible gain or loss to CMS. The uncertainty will ultimately be resolved when one or more future events occur or fail to occur. A contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is probable, and the related future outflow or sacrifice of resources is measurable.

**Other Liabilities** are the retirement plans utilized by CMS employees; the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, CMS makes matching contributions equal to 7 percent of pay. The CMS does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of OPM.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which CMS is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, CMS also contributes the employer's matching share of Social Security taxes.

### Net Position

**Net Position** contains the following components:

**Unexpended Appropriations** include the portion of CMS' appropriations represented by undelivered orders and unobligated balances.

**Cumulative Results of Operations** represent the net results of operations since the inception of the program plus the cumulative amount of prior period adjustments.

### Statement of Net Cost

The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. Under the Government Performance and Results Act (GPRA), CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and SCHIP. The bulk of CMS' expenses are allocated to these programs. The MIP is included in Medicare. The costs related to the Program Management Appropriation are cost-allocated to all three major components. The net cost of operations of the CLIA program and other programs are shown

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

separately under “Other Activities.” Although the following terms do not appear in the Statement of Net Cost, they are an integral part in the calculation of a program’s net cost of operations:

**Program/Activity Costs** represent the gross costs or expenses incurred by CMS for all activities.

**Benefit Payments** are payments by Medicare contractors, CMS, and Medicaid State agencies to health care providers for their services.

**Administrative Expenses** represent the costs of doing business by CMS and its partners.

**Exchange Revenues** (or earned revenues) arise when a Government entity provides goods and services to the public or to another Government entity for a fee.

**Premiums Collected** are used to finance SMI benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

**Net Cost of Operations** is the difference between the program’s gross costs and its related exchange revenues.

### **Statement of Changes in Net Position**

The Statement of Changes in Net Position (SCNP) reports the change in net position during the fiscal year that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. The SCNP comprises the following major line items:

**Prior Period Adjustments** are either corrections of errors or changes in accounting principles with retroactive effect that increase or decrease net position.

**Budgetary Financing Sources** display financing sources and nonexchange revenue that are also budgetary resources, as reported on the Statement of Budgetary Resources.

**Appropriations Received** show the amounts of appropriations received in the current fiscal year.

**Budgetary Financing Sources (Other than Exchange Revenues)** arise primarily from exercise of the Government’s power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing.

**Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI trust fund in an amount equal to SECA tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.

**Employment Tax Revenue** is the primary source of financing for Medicare’s HI program. Medicare’s portion of payroll and self-employment taxes is collected under FICA and SECA. Employees and employers were both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contributed the full 2.9 percent of their net income.

**Transfers-in/Transfers-out** report the transfers of funds between CMS programs or between CMS and other Federal agencies. Examples include transfers made from CMS’ Payment to the Health Care Trust Fund appropriation to the HI and SMI trust funds and the transfers between the HI and SMI trust funds and CMS’ Program Management appropriation.

### **Statement of Budgetary Resources**

The Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement.

**Unobligated Balances—beginning of period** represent funds available. These funds are primarily HI and SMI trust fund balances invested by the Treasury.

**Budget Authority** represents the funds available through appropriations, direct spending authority,

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

obligations limitations, unobligated balances at the beginning of the period or transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

**Obligations Incurred** consist of expended authority and the change in undelivered orders. Current system limitations prevent CMS from reporting the recoveries of prior year obligations. OMB has exempted CMS from the Circular No. A-11 requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that CMS report all Medicare cash collections as an offsetting receipt beginning in FY 2005. Therefore, CMS has reported \$2.5 billion for offsetting receipts within the financial statements.

**Adjustments** are increases or (decreases) to budgetary resources. Increases include recoveries of prior year obligations; decreases include budgetary resources temporarily not available, rescissions, and cancellations of expired and no-year accounts.

### ***Statement of Financing***

The Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Statement of Net Cost differ from the obligation-based measures used in the Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS' general ledger, which supports the Report on Budget Execution (SF-133) and the Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Balance Sheet, Statement of Net Cost, and Statement of Changes in Net Position. A reconciling item has been entered on the Statement of Financing, which has been prepared on a consolidated basis, except for the budgetary information used to calculate net obligations (budgetary resources), which must be presented on a combined basis.

### ***Use of Estimates in Preparing Financial Statements***

Preparation of financial statements in accordance with Federal accounting standards requires CMS to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

### ***Intra-Governmental Relationships and Transactions***

In the course of its operations, CMS has relationships and financial transactions with numerous Federal agencies. For example, CMS interacts with the Social Security Administration (SSA) and Treasury. The SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B trust fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies.

### ***Reclassifications***

Certain FY 2004 balances have been reclassified to conform to FY 2005 financial statement presentations, the effect of which is immaterial.

### ***Estimation of Obligations Related to Canceled Appropriations***

As of September 30, 2005, CMS has canceled over \$137 million in cumulative obligations to FY 2000 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FYs 2001 through 2005 related to canceled appropriations, CMS anticipates an additional \$1 million will be paid from current year funds for canceled obligations.

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## NOTE 2:

### FUND BALANCES *(Dollars in Millions)*

<u>FY 2005</u>	<b>Consolidated Totals</b>
<b>FUND BALANCES:</b>	
<b>Trust Funds</b>	
HI Trust Fund Balance	\$366
SMI Trust Fund Balance	1,303
<b>Revolving Funds</b>	
CLIA	118
<b>Appropriated Funds</b>	
Medicaid	10,942
SCHIP	7,275
TWI	780
<b>Other Fund Types</b>	
CMS Suspense Account	5
<b>TOTAL FUND BALANCES</b>	<b>\$20,789</b>
<b>STATUS OF FUND BALANCES WITH TREASURY:</b>	
<b>Unobligated Balance</b>	
Available	\$2,647
Unavailable	451
<b>Obligated Balance not yet Disbursed</b>	54,164
<b>Non-Budgetary FBWT</b>	(36,473)
<b>TOTAL STATUS OF FUND BALANCES WITH TREASURY</b>	<b>\$20,789</b>

<u>FY 2004</u>	<b>Consolidated Totals</b>
<b>FUND BALANCES:</b>	
<b>Trust Funds</b>	
HI Trust Fund Balance	\$600
SMI Trust Fund Balance	1,943
<b>Revolving Funds</b>	
CLIA	122
<b>Appropriated Funds</b>	
Medicaid	15,245
SCHIP	8,323
TWI	328
<b>Other Fund Types</b>	
CMS Suspense Account	6
Program Management Reimbursables	3
<b>TOTAL FUND BALANCES</b>	<b>\$26,570</b>
<b>STATUS OF FUND BALANCES WITH TREASURY:</b>	
<b>Unobligated Balance</b>	
Available	\$10,356
Unavailable	820
<b>Obligated Balance not yet Disbursed</b>	50,324
<b>Non-Budgetary FBWT</b>	(34,930)
<b>TOTAL STATUS OF FUND BALANCES WITH TREASURY</b>	<b>\$26,570</b>

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities.

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### NOTE 3: TRUST FUND INVESTMENTS, NET *(Dollars in Millions)*

#### Medicare Investments

<u>FY 2005</u>	<u>Maturity Range</u>	<u>Interest Range</u>	<u>Value</u>
<b>HI</b>			
Certificate	June 2006	4 1/8%	\$2,257
Bonds	June 2006 to June 2020	3 1/2 - 8 1/8%	275,010
Accrued Interest			3,729
<b>TOTAL HI INVESTMENTS</b>			<b>\$280,996</b>
<b>SMI</b>			
Bonds	June 2008 to June 2016	4 1/8 - 6 7/8%	\$17,204
Accrued Interest			244
<b>TOTAL SMI INVESTMENTS</b>			<b>\$17,448</b>
<b>TOTAL MEDICARE INVESTMENTS</b>			<b>\$298,444</b>
<u>FY 2004</u>	<u>Maturity Range</u>	<u>Interest Range</u>	<u>Value</u>
<b>HI</b>			
Bonds	June 2005 to June 2019	3 1/2 - 8 3/4%	264,375
Accrued Interest			3,705
<b>TOTAL HI INVESTMENTS</b>			<b>\$268,080</b>
<b>SMI</b>			
Bonds	June 2006 to June 2016	4 5/8 - 7%	17,439
Accrued Interest			273
<b>TOTAL SMI INVESTMENTS</b>			<b>\$17,712</b>
<b>TOTAL MEDICARE INVESTMENTS</b>			<b>\$285,792</b>

Trust Fund Investments are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

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### NOTE 4: INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

#### FY 2005

	Medicare		Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI	SMI						
Expenditure Transfer-in	\$485	\$6,154	\$146	\$3	\$9	\$6,797	\$(6,797)	
Nonexpenditure Transfer-in	17,039	18,018				35,057	(35,057)	
Railroad Retirement Principal	454					454		\$454
<b>TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET</b>	<b>\$17,978</b>	<b>\$24,172</b>	<b>\$146</b>	<b>\$3</b>	<b>\$9</b>	<b>\$42,308</b>	<b>\$(41,854)</b>	<b>\$454</b>

#### FY 2004

	Medicare		Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI	SMI						
Expenditure Transfer-in	\$497	\$6,710	\$125	\$3	\$1	\$7,336	\$(7,336)	
Nonexpenditure Transfer-in	15,269	18,085				33,354	(33,354)	
Railroad Retirement Principal	421					421		\$421
<b>TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET</b>	<b>\$16,187</b>	<b>\$24,795</b>	<b>\$125</b>	<b>\$3</b>	<b>\$1</b>	<b>\$41,111</b>	<b>\$(40,690)</b>	<b>\$421</b>

Intragovernmental accounts receivable represent CMS claims for payment from other Federal agencies. CMS accounts receivable for transfers from the HI and SMI trust funds maintained by the Treasury Bureau of Public Debt (BPD) are eliminated against BPD's corresponding liabilities to CMS in the Consolidated Balance Sheet.

### NOTE 5: OTHER ASSETS

#### ***Anticipated Congressional Appropriation***

The CMS has recorded \$14,272 million in anticipated Congressional appropriations (\$9,248 in FY 2004) to cover liabilities incurred as of September 30 by the Medicaid program and the Payments to the Health Care Trust Funds, as discussed below:

#### **Medicaid**

Beginning in FY 1996, CMS has accrued an expense and liability for Medicaid claims incurred but not reported (IBNR) as of September 30. In FY 2005, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of \$9,099 million (\$3,603 million in FY 2004). A review of appropriation language by CMS' Office of General Counsel (OGC) has resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the

entire IBNR amount to be reported as a funded liability. Consequently, CMS has recorded an \$9,099 million anticipated appropriation in FY 2005 (\$3,603 million in FY 2004) for IBNR claims that exceed the available appropriation.

#### **Payments to the Health Care Trust Funds**

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums payable and deposited in the Trust Fund. Section 1844 also outlines the ratio for the match and the method to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year. The appropriated amount is an estimate calculated annually by CMS' OACT and can be insufficient in

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any particular fiscal year. In FY 2005, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30 approximately \$5,107.4 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional \$65.3 million in interest on the unmatched amount, leaving a cumulative liability of about \$5,173 million owed to SMI. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Consequently, CMS has recorded a \$5,173 million anticipated appropriation in FY 2005 for the amount of the unmatched SMI premiums. Although the actual transfer of funds will occur in

FY 2006, CMS has reported the \$5,173 million as revenues earned in FY 2005.

In addition, the \$5,173 million in unmatched SMI premiums is reported as a liability "requiring or generating resources in future periods" on the Consolidated Statement of Financing.

### **Other—Managed Care Advances**

Medicare Advantage plans were issued an advance payment on September 30, 2005 in the amount of \$4,099 million for services that will be provided in October 2005. The remaining \$102 million (\$101 million in FY 2004) in Other Assets represent advances made to various contractors and vendors.

### **NOTE 6:**

### **ACCOUNTS**

### **RECEIVABLE, NET** *(Dollars in Millions)*

FY 2005	Medicare HI	SMI	Medicaid	All Others	Consolidated Total
<b>Provider &amp; Beneficiary Overpayment</b>					
Accounts Receivable Principal	\$550	\$701		\$26	\$1,277
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(189)</u>	<u>(374)</u>		<u>(16)</u>	<u>(579)</u>
Accounts Receivable, Net	361	327		10	698
<b>Medicare Secondary Payer (MSP)</b>					
Accounts Receivable Principal	147	105		8	260
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(65)</u>	<u>(53)</u>		<u>(5)</u>	<u>(123)</u>
Accounts Receivable, Net	82	52		3	137
<b>CMPs &amp; Other Restitutions</b>					
Accounts Receivable Principal	170	359		1	530
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(115)</u>	<u>(287)</u>		<u>(1)</u>	<u>(403)</u>
Accounts Receivable, Net	55	72			127
<b>Fraud and Abuse</b>					
Accounts Receivable Principal	116	226			342
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(116)</u>	<u>(208)</u>			<u>(324)</u>
Accounts Receivable, Net		18			18
<b>Managed Care</b>					
Accounts Receivable Principal	105	85		3	193
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(1)</u>	<u>(3)</u>		<u>(3)</u>	<u>(7)</u>
Accounts Receivable, Net	104	82			186
<b>Medicare Premiums</b>					
Accounts Receivable Principal	212	533			745
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(48)</u>	<u>(46)</u>			<u>(94)</u>
Accounts Receivable, Net	164	487			651
<b>Audit Disallowances</b>					
Accounts Receivable Principal	4	9	\$171		184
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(1)</u>	<u>(2)</u>	<u>(119)</u>		<u>(122)</u>
Accounts Receivable, Net	3	7	52		62
<b>Other Accounts Receivable</b>					
Accounts Receivable Principal			104	19	123
<u>Less: Allowance for Uncollectible Accounts</u>			<u>(101)</u>	<u>(17)</u>	<u>(118)</u>
Accounts Receivable, Net			3	2	5
<b>TOTAL ACCOUNTS RECEIVABLE PRINCIPAL</b>	<b>\$1,304</b>	<b>\$2,018</b>	<b>\$275</b>	<b>\$57</b>	<b>\$3,654</b>
Less: Allowance for Uncollectible Accounts Receivable	(535)	(973)	(220)	(42)	(1,770)
<b>TOTAL ACCOUNTS RECEIVABLE, NET</b>	<b>\$769</b>	<b>\$1,045</b>	<b>\$55</b>	<b>\$15</b>	<b>\$1,884</b>

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FY 2004	Medicare		Medicaid	All Others	Consolidated Total
	HI	SMI			
<b>Provider &amp; Beneficiary Overpayment</b>					
Accounts Receivable Principal	\$595	\$721		\$55	\$1,371
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(224)</u>	<u>(394)</u>		<u>(36)</u>	<u>(654)</u>
Accounts Receivable, Net	371	327		19	717
<b>Medicare Secondary Payer (MSP)</b>					
Accounts Receivable Principal	154	89		12	255
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(78)</u>	<u>(49)</u>		<u>(8)</u>	<u>(135)</u>
Accounts Receivable, Net	76	40		4	120
<b>CMPs &amp; Other Restitutions</b>					
Accounts Receivable Principal	125	287		1	413
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(119)</u>	<u>(278)</u>		<u>(1)</u>	<u>(398)</u>
Accounts Receivable, Net	6	9			15
<b>Fraud and Abuse</b>					
Accounts Receivable Principal	116	211			327
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(115)</u>	<u>(207)</u>			<u>(322)</u>
Accounts Receivable, Net	1	4			5
<b>Managed Care</b>					
Accounts Receivable Principal	2	7		3	12
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(2)</u>	<u>(4)</u>		<u>(3)</u>	<u>(9)</u>
Accounts Receivable, Net		3			3
<b>Medicare Premiums</b>					
Accounts Receivable Principal	160	430			590
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(43)</u>	<u>(40)</u>			<u>(83)</u>
Accounts Receivable, Net	117	390			507
<b>Audit Disallowances</b>					
Accounts Receivable Principal	4	8	\$1,141		1,153
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(1)</u>	<u>(2)</u>	<u>(617)</u>		<u>(620)</u>
Accounts Receivable, Net	3	6	524		533
<b>Other Accounts Receivable</b>					
Accounts Receivable Principal			90	21	111
<u>Less: Allowance for Uncollectible Accounts</u>			<u>(88)</u>	<u>(18)</u>	<u>(106)</u>
Accounts Receivable, Net			2	3	5
<b>TOTAL ACCOUNTS RECEIVABLE PRINCIPAL</b>	<b>\$1,156</b>	<b>\$1,753</b>	<b>\$1,231</b>	<b>\$92</b>	<b>\$4,232</b>
Less: Allowance for Uncollectible Accounts Receivable	(582)	(974)	(705)	(66)	(2,327)
<b>TOTAL ACCOUNTS RECEIVABLE, NET</b>	<b>\$574</b>	<b>\$779</b>	<b>\$526</b>	<b>\$26</b>	<b>\$1,905</b>

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Medicare accounts receivable are primarily composed of provider and beneficiary overpayments, and MSP overpayments. The MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount.

### ***Currently Not Reportable/Currently Not Collectible Debt***

In FY 1999, CMS implemented a number of policy changes in the reporting of delinquent accounts receivable. Provisions within the Office of Management and Budget (OMB) Circular A-129, ***Managing Federal Credit Programs***, allow an agency to move certain uncollectible delinquent debts into memorandum entries, which removes the receivable from the financial statements. The policy provides for certain debts to be written off closed without any further collection activity or reclassified as Currently Not Reportable. (This is also referred to as Currently Not Reportable/Collectible). This category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements because of the unlikelihood of collecting it. While these debts are not reported on the financial statements, the Currently Not Reportable/Collectible process permits and requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

In FY 2005, CMS continued the implementation of this policy and again performed analyses of its accounts receivable. CMS also continued to manage this debt by referring a significant portion of debt to Treasury for offset and cross-servicing in accordance with the Debt Collection Improvement Act of 1996.

### ***Recognition of MSP Accounts Receivable***

MSP accounts receivable are recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance reflects an adjustment for expected reductions to group

health plan accounts receivable for situations where CMS receives valid documented defenses to its recovery demands.

### ***Write Offs and Adjustments***

The implementation of the revised policies and other initiatives undertaken in recent fiscal years resulted in significant adjustments and write offs made to CMS' accounts receivable balance. CMS' financial reporting reflected additional adjustments, resulting from the validation and reconciliation efforts performed, revised policies and supplemental guidance provided by CMS to the Medicare contractors. The accounts receivable ending balance continues to reflect adjustments for accounts receivable which have been reclassified as Currently Not Reportable debt.

The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on an historic analysis of actual recoveries and the rate of disallowances found in favor of the States. Such disallowances are not considered bad debts; the States elect to retain the funds until final resolution.

### ***Non-entity Assets***

Assets are either "entity" (the reporting entity holds and has authority to use the assets in its operations) or "non-entity" (the reporting agency holds but does not have authority to use in its operations). Before FY 2000 CMS reported its entity and non-entity assets in separate sections of the balance sheet. Since FY 2000 CMS has reported its entity and non-entity assets in a single combined section.

The only non-entity assets on CMS' Consolidating Balance Sheet are receivables for interest and penalties, net for the amount of \$13 million (\$22 million in FY 2004). The accrued interest associated with Provider and Beneficiary, MSP and Managed Care overpayments appear under All Others.

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### NOTE 7:

### OTHER LIABILITIES *(Dollars in Millions)*

<u>FY 2005</u>	HI	Medicare	SMI	Medicaid	All Others	Consolidated Total
<b>Intragovernmental:</b>						
Uncollected Revenue due Treasury	\$109		\$279		\$13	\$401
Other	8		12	\$3	9	32
<b>TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES</b>	<b>\$117</b>		<b>\$291</b>	<b>\$3</b>	<b>\$22</b>	<b>\$433</b>
Deferred Revenue	\$59		\$208			\$267
Suspense Account Deposit Funds					\$7	7
Other	1,109		543			1,652
<b>TOTAL OTHER LIABILITIES</b>	<b>\$1,168</b>		<b>\$751</b>		<b>\$7</b>	<b>\$1,926</b>

<u>FY 2004</u>	HI	Medicare	SMI	Medicaid	All Others	Consolidated Total
<b>Intragovernmental:</b>						
Uncollected Revenue due Treasury	\$64		\$223		\$22	\$309
Other	13		20	\$2		35
<b>TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES</b>	<b>\$77</b>		<b>\$243</b>	<b>\$2</b>	<b>\$22</b>	<b>\$344</b>
Deferred Revenue	\$54		\$167			\$221
Suspense Account Deposit Funds					\$10	10
Other	1,286		585		2	1,873
<b>TOTAL OTHER LIABILITIES</b>	<b>\$1,340</b>		<b>\$752</b>		<b>\$12</b>	<b>\$2,104</b>

The CMS routinely receives premium payments on behalf of select categories of beneficiaries from third parties. In some instances, the payments received exceed the amount billed. As of the end of the accounting period, the excess collections are reported as deferred revenue received that will be applied against the next month's premium bill.

### Contingencies

The CMS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. The CMS has accrued a contingent liability where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined.

Included in other liabilities are estimated amounts for a contingent liability payable to States (to reimburse them for payments they have paid on behalf of beneficiaries) at an amount of approximately \$1,648 million (\$1,867 million in FY 2004), for probable unasserted claims that resulted from processing errors where incorrect Medicare eligibility determinations were made. No claims have been filed. Because appropriation law requires Congress to authorize the transfer of funds out of the Medicare Trust Funds into an appropriation account, the Medicare Trust Funds cannot reimburse the Health Program accounts in the general fund of the Treasury absent Congressional authorization. The CMS does not intend to seek such Congressional authorization and there will be no transactions recorded between the Trust Funds and the Health Programs' accounts in the general fund.

The following contingent liabilities for which a loss has been determined to be reasonably possible have not been accrued in the CMS financial statements:

The CMS expects that as of September 30, 2005, it is reasonably possible that as much as \$2.8 billion could be owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals. Two United States Circuit Courts of Appeals have decided cases in which CMS has litigated these issues. One court has ruled in favor of CMS, reaffirming CMS' decision to deny cost report reopenings. The other court has ruled against CMS and instructed CMS to reopen certain providers' cost reports. CMS intends to vigorously contest this latter decision. Any potential payment of any funds related to these claims would be based on the providers' ability to comply with the legal requirement that they provide adequate documentation to support their claims and overcome any other legal defenses.

Under earlier applicable law, Medicare, in certain circumstances, reimbursed hospitals for losses incurred on the disposal of assets. The CMS is currently defending claims relating to a number of mergers and consolidations that occurred between non-profit hospitals prior to the 1997 change in the law. The CMS expects that as of September 30, 2005, it is reasonably possible that from \$119 million to \$259 million may be owed to providers for unreimbursed costs reported on their Medicare cost reports. CMS intends to vigorously defend this case.

As of September 30, 2005, management expects that it is reasonably possible that up to \$106 million may be owed for asserted claims associated with Medicaid cost disallowance cases.

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### ***Appeals at the Provider Reimbursement Review Board***

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2004, there were 5,580 (7,634 in FY 2003) PRRB cases under appeal. A total of 2,301 (2,337 in FY 2004) new cases were filed in FY 2005. The PRRB rendered decisions on 72 (46

in FY 2004) cases in FY 2005 and 2,072 (4,345 in FY 2004) additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 72 cases that were decided in FY 2005, a reasonable liability estimate cannot be projected for the value of the 5,737 (5,580 in FY 2004) cases remaining on appeal as of September 30, 2005. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

### **NOTE 8: ENTITLEMENT BENEFITS DUE AND PAYABLE** *(Dollars in Millions)*

FY 2005	Medicare			Medicaid	All Others	Consolidated Total
	HI	SMI	Total			
Medicare Benefits Payable (1)	\$16,547	\$16,337	\$32,884			\$32,884
HMO Benefits	259	230	489			489
Demonstration Projects		2	2			2
Transitional Assistance		24	24			24
Undocumented Aliens (1)					\$250	250
Medicaid Benefits Payable (2)				\$19,786		19,786
Medicaid Audit/Program Disallowances (3)				319		319
<b>TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE</b>	<b>\$16,806</b>	<b>\$16,593</b>	<b>\$33,399</b>	<b>\$20,105</b>	<b>\$250</b>	<b>\$53,754</b>

FY 2004	Medicare			Medicaid	Consolidated Total
	HI	SMI	Total		
Medicare Benefits Payable (1)	\$15,016	\$14,778	\$29,794		\$29,794
Demonstration Projects and HMO Benefits	27	24	51		51
Transitional Assistance		30	30		30
Medicaid Benefits Payable (2)				\$18,900	18,900
Medicaid Audit/Program Disallowances (3)				454	454
<b>TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE</b>	<b>\$15,043</b>	<b>\$14,832</b>	<b>\$29,875</b>	<b>\$19,354</b>	<b>\$49,229</b>

- (1) Medicare benefits payable consists of a \$32.9 billion estimate (\$29.8 billion in FY 2004) by CMS' Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2005. The liability represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for 2005 that were paid in 2006 and (e) an estimate of retroactive settlements of cost reports. Managed care benefits payable includes amounts incurred related to risk adjustments and other estimates.

Undocumented aliens consist of a \$250 million estimate of emergency health services furnished by providers to eligible aliens but not paid as of September 30, 2005. As part of the MMA, Section 1011, Congress mandated HHS directly pay hospitals, physicians, and ambulance providers for their otherwise un-reimbursed costs of providing services required by Section 1867 of the Social Security Act related to undocumented aliens.

- (2) Medicaid benefits payable of \$19.8 billion (\$18.9 billion in FY 2004) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2005.
- (3) Medicaid audit and program disallowances of \$319 million (\$454 million in FY 2004) are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. The CMS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There are also outstanding reviews of the State expenditures in which a final determination has not been made. The monetary effect of those reviews is not known until a final decision is rendered. In the opinion of management, the solution of these matters will not have a material impact on the results of operations and financial conditions of CMS. Depending on the outcome of these reviews, the State or CMS could be owed funds.

Note that a portion of the Medicaid Entitlement Benefits Due and Payable is not covered by budgetary resources. Refer to Note 9 for the classification between the covered and not covered portions of this liability.

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### NOTE 9:

### LIABILITIES NOT COVERED BY BUDGETARY RESOURCES *(Dollars in Millions)*

<u>FY 2005</u>	<u>Medicare</u> <u>HI</u>	<u>SMI</u>	<u>Medicaid</u>	<u>All</u> <u>Others</u>	<u>Combined</u> <u>Total</u>	<u>Intra-CMS</u> <u>Eliminations</u>	<u>Consolidated</u> <u>Total</u>
<b>Intragovernmental:</b>							
Accrued Payroll and Benefits	\$1	\$3			\$4		\$4
Liability for Unmatched SMI Premiums		5,173			5,173	\$(5,173)	
<b>TOTAL INTRAGOVERNMENTAL</b>	<b>\$1</b>	<b>\$5,176</b>			<b>\$5,177</b>	<b>\$(5,173)</b>	<b>\$4</b>
Entitlement Benefits Due and Payable			\$9,470		\$9,470		\$9,470
Federal Employee and Veterans' Benefits	3	6	1		10		10
Accrued Payroll and Benefits	10	19	3		32		32
Contingent Liabilities	1,107	541			1,648		1,648
<b>TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES</b>	<b>\$1,121</b>	<b>\$5,742</b>	<b>\$9,474</b>		<b>\$16,337</b>	<b>\$(5,173)</b>	<b>\$11,164</b>
<b>TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES</b>	<b>\$34,591</b>	<b>\$36,512</b>	<b>\$10,640</b>	<b>\$279</b>	<b>\$82,022</b>	<b>\$(36,681)</b>	<b>\$45,341</b>
<b>TOTAL LIABILITIES</b>	<b>\$35,712</b>	<b>\$42,254</b>	<b>\$20,114</b>	<b>\$279</b>	<b>\$98,359</b>	<b>\$(41,854)</b>	<b>\$56,505</b>

<u>FY 2004</u>	<u>Medicare</u> <u>HI</u>	<u>SMI</u>	<u>Medicaid</u>	<u>All</u> <u>Others</u>	<u>Combined</u> <u>Total</u>	<u>Intra-CMS</u> <u>Eliminations</u>	<u>Consolidated</u> <u>Total</u>
<b>Intragovernmental:</b>							
Accrued Payroll and Benefits	\$1	\$2			\$3		\$3
Liability for Unmatched SMI Premiums		5,645			5,645	\$(5,645)	
<b>TOTAL INTRAGOVERNMENTAL</b>	<b>\$1</b>	<b>\$5,647</b>			<b>\$5,648</b>	<b>\$(5,645)</b>	<b>\$3</b>
Entitlement Benefits Due and Payable			\$10,039		\$10,039		\$10,039
Federal Employee and Veterans' Benefits	3	6	1		10		10
Accrued Payroll and Benefits	10	20	1		31		31
Contingent Liabilities	1,283	584			1,867		1,867
<b>TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES</b>	<b>\$1,297</b>	<b>\$6,257</b>	<b>\$10,041</b>		<b>\$17,595</b>	<b>\$(5,645)</b>	<b>\$11,950</b>
<b>TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES</b>	<b>\$31,059</b>	<b>\$35,047</b>	<b>\$9,320</b>	<b>\$34</b>	<b>\$75,460</b>	<b>\$(35,045)</b>	<b>\$40,415</b>
<b>TOTAL LIABILITIES</b>	<b>\$32,356</b>	<b>\$41,304</b>	<b>\$19,361</b>	<b>\$34</b>	<b>\$93,055</b>	<b>\$(40,690)</b>	<b>\$52,365</b>

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. The CMS recognizes such liabilities for employee annual leave earned but not taken, amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments, and for portions of the Entitlement Benefits Due and Payable liability for which no obligations have been incurred. For CMS revolving funds, all liabilities are funded as they occur.

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## NOTE 10: NET COST OF OPERATIONS *(Dollars in Millions)*

FY 2005	Medicare			Health		All Others	Consolidated Totals
	HI	SMI	Total	Medicaid	SCHIP		
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	\$156,597	\$128,699	\$285,296				\$285,296
Managed Care	23,783	20,764	44,547				44,547
Medicaid/SCHIP/TWI				\$182,438	\$5,129	\$325	187,892
CLIA						63	63
TOTAL PROGRAM/ACTIVITY COSTS	\$180,380	\$149,463	\$329,843	\$182,438	\$5,129	\$388	\$517,798
OPERATING COSTS							
Medicare Integrity Program	\$1,095		\$1,095				\$1,095
Quality Improvement Organizations	319	\$79	398				398
Bad Debt Expense and Writeoffs	(45)	(7)	(52)	\$(483)			(535)
Reimbursable Expenses	2	5	7	1			8
Administrative Expenses	919	1,686	2,605	265	\$6		2,876
Depreciation and Amortization	27	18	45	3			48
Imputed Cost Subsidies	10	21	31	3			34
TOTAL OPERATING COSTS	\$2,327	\$1,802	\$4,129	\$(211)	\$6		\$3,924
TOTAL COSTS	\$182,707	\$151,265	\$333,972	\$182,227	\$5,135	\$388	\$521,722
LESS: EXCHANGE REVENUES:							
Medicare Premiums	\$2,303	\$35,939	\$38,242				\$38,242
CLIA Revenues						\$60	60
Other Earned Revenues	11	6	17	\$1			18
TOTAL EXCHANGE REVENUES	\$2,314	\$35,945	\$38,259	\$1		\$60	\$38,320
TOTAL NET COST OF OPERATIONS	\$180,393	\$115,320	\$295,713	\$182,226	\$5,135	\$328	\$483,402

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FY 2004	Medicare			Health			Consolidated Totals	
	HI	SMI	Total	Medicaid	SCHIP	All Others		
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	\$146,295	\$113,778	\$260,073				\$260,073	
Managed Care	20,920	18,683	39,603				39,603	
Medicaid/SCHIP/TWI				\$176,800	\$4,607	\$34	181,441	
CLIA						64	64	
TOTAL PROGRAM/ACTIVITY COSTS	\$167,215	\$132,461	\$299,676	\$176,800	\$4,607	\$98	\$481,181	
OPERATING COSTS								
Medicare Integrity Program	\$1,057		\$1,057				\$1,057	
Quality Improvement Organizations	314	\$79	393				393	
Bad Debt Expense and Writeoffs	(1,282)	(443)	(1,725)	\$67			(1,658)	
Reimbursable Expenses	2	3	5				5	
Administrative Expenses	818	1,640	2,458	191	\$4		2,653	
Depreciation and Amortization	1	3	4				4	
Imputed Cost Subsidies	10	21	31	2			33	
TOTAL OPERATING COSTS	\$920	\$1,303	\$2,223	\$260	\$4		\$2,487	
TOTAL COSTS	\$168,135	\$133,764	\$301,899	\$177,060	\$4,611	\$98	\$483,668	
LESS: EXCHANGE REVENUES:								
Medicare Premiums	\$1,799	\$30,341	\$32,140				\$32,140	
CLIA Revenues						\$60	60	
Other Earned Revenues	8	3	11				11	
TOTAL EXCHANGE REVENUES	\$1,807	\$30,344	\$32,151			\$60	\$32,211	
TOTAL NET COST OF OPERATIONS	\$166,328	\$103,420	\$269,748	\$177,060	\$4,611	\$38	\$451,457	

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlaid by Treasury even though some funds may have been used to pay for assets such as property and equipment. The CMS administrative costs have been allocated to the Medicare, Medicaid, SCHIP

and TWI programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include \$1.3 billion (\$1.3 billion in FY 2004) paid to Medicare contractors to carry out their responsibilities as CMS' agents in the administration of the Medicare program.

# CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

## NOTE 11:

### BUDGETARY FINANCING

### SOURCES: OTHER ADJUSTMENTS *(Dollars in Millions)*

<u>FY 2005</u>	<u>Medicare</u>					<u>Consolidated</u>
	HI	SMI	Medicaid	SCHIP	Other	Total
<b>Unexpended Appropriations</b>						
Withdrawal of Expired or Canceled Year Authority		\$(2,105)			\$(3)	\$(2,108)
Net Change in Anticipated Congressional Appropriation		(472)	\$5,496			5,024
Return of Indefinite Authority			(2,600)			(2,600)
<b>TOTAL OTHER ADJUSTMENTS</b>		<b>\$(2,577)</b>	<b>\$2,896</b>		<b>\$(3)</b>	<b>\$316</b>

<u>FY 2004</u>	<u>Medicare</u>					<u>Consolidated</u>
	HI	SMI	Medicaid	SCHIP	Other	Total
<b>Unexpended Appropriations</b>						
Withdrawal of Expired or Canceled Year Authority	\$(45)				\$(10)	\$(55)
Net Change in Anticipated Congressional Appropriation		2,265	\$(4,847)			(2,582)
<b>TOTAL OTHER ADJUSTMENTS</b>	<b>\$(45)</b>	<b>\$2,265</b>	<b>\$(4,847)</b>		<b>\$(10)</b>	<b>\$(2,637)</b>

Other adjustments include increases or decreases to Unexpended Appropriations that result from transactions other than the receipt of appropriations, transfers in or out of appropriated authority, or the expenditure of appropriations. Such transactions include the return to the Treasury general fund of expired or canceled year authority, the net increase or decrease resulting from the accrual of anticipated Congressional appropriations, or other adjustments.

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### NOTE 12:

### TAXES AND OTHER

### NON-EXCHANGE REVENUE *(Dollars in Millions)*

<b>FY 2005</b>	<b>Medicare</b>		<b>Consolidated Total</b>
	<b>HI</b>	<b>SMI</b>	
FICA Tax Receipts	\$157,702		\$157,702
SECA Tax Receipts	11,252		11,252
Trust Fund Investment Interest	15,149	\$1,335	16,484
Civil Monetary Penalties and Damages	354		354
Other Income		1	1
<b>TAXES AND OTHER NON-EXCHANGE REVENUE</b>	<b>\$184,457</b>	<b>\$1,336</b>	<b>\$185,793</b>

<b>FY 2004</b>	<b>Medicare</b>		<b>Consolidated Total</b>
	<b>HI</b>	<b>SMI</b>	
FICA Tax Receipts	\$142,659		\$142,659
SECA Tax Receipts	10,789		10,789
Trust Fund Investment Interest	14,972	\$1,602	16,574
Civil Monetary Penalties and Damages	355		355
<b>TAXES AND OTHER NON-EXCHANGE REVENUE</b>	<b>\$168,775</b>	<b>\$1,602</b>	<b>\$170,377</b>

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI Trust Fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the

Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

# CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

## NOTE 13:

### OTHER TRANSFERS-IN/OUT *(Dollars in Millions)*

#### FY 2005

Transfers-in Without Reimbursement	Medicare		Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI	SMI						
Medicare Benefit Transfers	\$184,531	\$151,325				\$335,856	\$(335,856)	
Transfers to HCFAC	1,057					1,057	(1,057)	
Federal Matching Contributions		113,529				113,529	(113,529)	
Transitional Assistance Benefits		1,125				1,125	(1,125)	
State Low Income Determination		73	\$73			146	(146)	
Allocation to CMS Programs	796	1,528	274	\$6		2,604	(2,604)	
Fraud and Abuse Appropriation	114					114	(114)	
Transfer-Uninsured Coverage	286					286	286	
Prog. Mngmt. Admin. Expense (1)	215					215	215	
Income Tax OASDI Benefits (2)	8,765					8,765	(8,765)	
Railroad Retirement Board	477					477		477
Criminal Fines	359					359		359
Medicaid Part B Premiums			242			242	(242)	
Interest Adjustment	1	(1)						
Gifts and Miscellaneous	1	1				2		2
<b>TOTAL TRANSFERS-IN</b>	<b>\$196,602</b>	<b>\$267,580</b>	<b>\$589</b>	<b>\$6</b>		<b>\$464,777</b>	<b>\$(463,939)</b>	<b>\$838</b>

#### FY 2005

Transfers-out Without Reimbursement	Medicare		Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI	SMI						
SSA Administrative Expenses	\$(662)	\$(577)				\$(1,239)		\$(1,239)
Medicare Benefit Transfers	(184,531)	(151,325)				(335,856)	\$335,856	
Transfers to HCFAC	(1,057)					(1,057)	1,057	
Federal Matching Contributions		(113,529)				(113,529)	113,529	
Transitional Assistance Benefits		(1,125)				(1,125)	1,125	
State Low Income Determination		(73)				(73)	73	
Transfers to Program Management	(895)	(1,783)				(2,678)	2,677	(1)
Fraud and Abuse Appropriation	(114)					(114)	114	
Transfer-Uninsured Coverage	(286)					(286)	286	
Prog. Mngmt. Admin. Expense (1)	(215)					(215)	215	
Income Tax OASDI Benefits (2)	(8,765)					(8,765)	8,765	
Medicaid Part B Premiums		(242)				(242)	242	
Office of the Secretary	(31)	(28)				(59)		(59)
Office of the Secretary OIG		(25)				(25)		(25)
Payment Assessment Commission	(6)	(4)				(10)		(10)
Railroad Retirement Board		(6)				(6)		(6)
<b>TOTAL TRANSFERS-OUT</b>	<b>\$(196,562)</b>	<b>\$(268,717)</b>				<b>\$(465,279)</b>	<b>\$463,939</b>	<b>\$(1,340)</b>
<b>TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT</b>	<b>\$(40)</b>	<b>\$(1,137)</b>	<b>\$589</b>	<b>\$6</b>		<b>\$(502)</b>		<b>\$(502)</b>

# CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

## FY 2004

Transfers-in Without Reimbursement	Medicare		Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI	SMI						
Medicare Benefit Transfers	\$178,835	\$149,304				\$328,139	\$(328,139)	
Transfers to HCFAC	1,063					1,063	(1,063)	
Federal Matching Contributions		96,783				96,783	(96,783)	
Transitional Assistance Benefits		216				216	(216)	
Allocation to CMS Programs	1,044	2,282	\$266	\$5	\$(6)	3,591	(3,591)	
Fraud and Abuse Appropriation	114					114	(114)	
Transfer-Uninsured Coverage	365					365	(365)	
Prog. Mngmt. Admin. Expense (1)	201					201	(201)	
Military Service General Fund Transfer	173					173	(173)	
Military Service Adjustment	(147)					(147)		(147)
Income Tax OASDI Benefits (2)	8,577					8,577	(8,577)	
Railroad Retirement Board	434					434		434
Criminal Fines	315					315		315
Medicaid Part B Premiums			168			168	(168)	
Interest Adjustment	(25)					(25)		(25)
Gifts and Miscellaneous	2	2				4		4
<b>TOTAL TRANSFERS-IN</b>	<b>\$190,951</b>	<b>\$248,587</b>	<b>\$434</b>	<b>\$5</b>	<b>\$(6)</b>	<b>\$439,971</b>	<b>\$(439,390)</b>	<b>\$581</b>

## FY 2004

Transfers-out Without Reimbursement	Medicare		Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI	SMI						
SSA Administrative Expenses	\$(643)	\$(1,098)				\$(1,741)		\$(1,741)
Medicare Benefit Transfers	(178,835)	(149,304)				(328,139)	\$328,139	
Transfers to HCFAC	(1,063)					(1,063)	1,063	
Federal Matching Contributions		(96,783)				(96,783)	96,783	
Transitional Assistance Benefits		(216)				(216)	216	
Transfers to Program Management	(1,222)	(2,369)				(3,591)	3,591	
Fraud and Abuse Appropriation	(114)					(114)	114	
Transfer-Uninsured Coverage	(365)					(365)	365	
Prog. Mngmt. Admin. Expense (1)	(201)					(201)	201	
Income Tax OASDI Benefits (2)	(8,577)					(8,577)	8,577	
Military Service General Fund Transfer					\$(173)	(173)	173	
Medicaid Part B Premiums		(168)				(168)	168	
Office of the Secretary	(5)	(3)				(8)		(8)
Payment Assessment Commission	(6)	(3)				(9)		(9)
Railroad Retirement Board		(6)				(6)		(6)
<b>TOTAL TRANSFERS-OUT</b>	<b>\$(191,031)</b>	<b>\$(249,950)</b>			<b>\$(173)</b>	<b>\$(441,154)</b>	<b>\$439,390</b>	<b>\$(1,764)</b>
<b>TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT</b>	<b>\$(80)</b>	<b>\$(1,363)</b>	<b>\$434</b>	<b>\$5</b>	<b>\$(179)</b>	<b>\$(1,183)</b>		<b>\$(1,183)</b>

- (1) During FY 2005, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund \$215 million (\$201 million in FY 2004) to cover the Medicaid, SCHIP and TWI programs' share of CMS' administrative costs.
- (2) The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of Old Age Survivors and Disability Insurance (OASDI) benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent. The revenues, resulting from this increase, are transferred to the HI Trust Fund.

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### ***Federal Matching Contributions***

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust

funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was \$66.60 from October 2004 through December 2004 and \$78.20 from January 2005 through September 2005. Premiums collected from beneficiaries totaled \$35.9 billion (\$30.3 billion in FY 2004) and were matched by a \$113.5 billion (\$96.8 billion in FY 2004) contribution from the Federal government.

### **NOTE 14:**

### **STATEMENT OF BUDGETARY RESOURCES DISCLOSURES** *(Dollars in Millions)*

The amounts of direct and reimbursable obligations incurred against amounts apportioned

under Category A, Category B and Exempt from Apportionment are shown below:

<b><u>FY 2005</u></b>	<b>Direct</b>	<b>Reimbursable</b>	<b>Combined Totals</b>
Category A	\$8,522	\$68	\$8,590
Category B	312,255	13	312,268
Exempt	346,561		346,561
<b>TOTAL</b>	<b>\$667,338</b>	<b>\$81</b>	<b>\$667,419</b>

<b><u>FY 2004</u></b>	<b>Direct</b>	<b>Reimbursable</b>	<b>Combined Totals</b>
Category A	\$6,150	\$72	\$6,222
Category B	283,360	2	283,362
Exempt	307,819		307,819
<b>TOTAL</b>	<b>\$597,329</b>	<b>\$74</b>	<b>\$597,403</b>

## CMS PRINCIPAL STATEMENTS AND NOTES FY 2005

### ***Legal Arrangements Affecting Use of Unobligated Balances***

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is reported as Temporarily Not Available

Pursuant to Public Law in the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of \$258,025 million (\$246,876 million in FY 2004) as of September 30, 2005 are included in Investments on the Balance Sheet. The following table presents trust fund activities and balances for FY 2005 and FY 2004 (in millions):

<u>FY 2005</u>	<b>Combined Balances</b>
<b>TRUST FUND BALANCES, BEGINNING</b>	<b>\$246,876</b>
Receipts	350,969
Less Obligations	339,820
Less Transfers	
Excess of Receipts Over Obligations	11,149
<b>TRUST FUND BALANCES, ENDING</b>	<b>\$258,025</b>

<u>FY 2004</u>	<b>Combined Balances</b>
<b>TRUST FUND BALANCES, BEGINNING</b>	<b>\$242,955</b>
Receipts	303,436
Less Obligations	299,515
Excess of Receipts Over Obligations	3,921
<b>TRUST FUND BALANCES, ENDING</b>	<b>\$246,876</b>

### **Explanations of Differences Between the Statement of Budgetary Resources and the Budget of the United States Government for FY 2004** (in millions)

	<b>Budgetary Resources</b>	<b>Net Outlays (Less Offsetting Receipts)</b>
Statement of Budgetary Resources	\$608,579	\$448,461
Adjustments for Expired Accounts	(2,232)	
Other Adjustments	1,468	1,602
<b>PRESIDENT'S BUDGET (actual)</b>	<b>\$607,815</b>	<b>\$450,063</b>

The Other Adjustments Line includes an increase to budgetary resources in the amount of \$1,533 million for the amounts reported in the President's Budget but reported by the Centers for Disease Control (CDC) and the Department of Treasury (Treasury) and a decrease of \$65 million for offsetting collections.

The Other Adjustments Line also includes an increase to net outlays in the amount of \$1,429 million for the amounts reported in the President's Budget but reported by the CDC and Treasury, and an increase of \$173 million for Military Service General Fund Transfer reported as offsetting receipt on SBR but not reported as an offsetting receipt in the President's Budget.



# Required Supplementary Stewardship Information

Medicare, the largest health insurance program in the country, has helped fund medical care for the Nation's aged and disabled for four decades. The recent Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA) introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a new prescription drug benefit. A separate Part D account within the SMI trust fund will handle the transactions for this new coverage. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included on pages 3-5 of this financial report.

The required supplementary stewardship information (RSSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSSI material is generally drawn from the *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

Printed copies of the Trustees Report may be obtained from CMS Office of the Actuary (410-786-6386) or can be downloaded from [www.cms.hhs.gov/publications/trusteesreport/default.asp](http://www.cms.hhs.gov/publications/trusteesreport/default.asp).

# ACTUARIAL PROJECTIONS

## Cashflow in Nominal Dollars

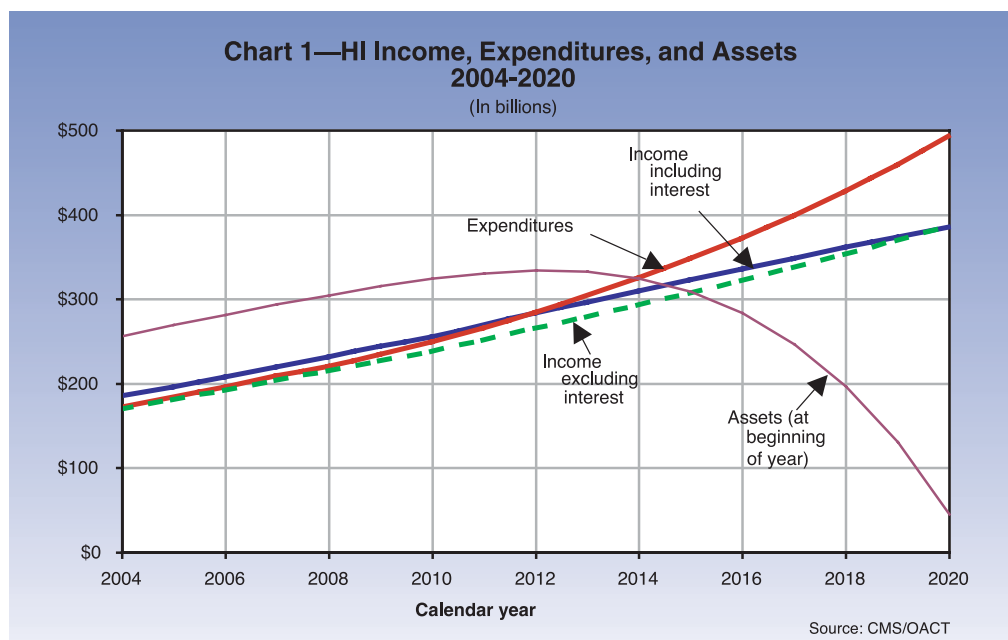
Using nominal dollars<sup>1</sup> for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that can be reasonably comprehended in today's experience.

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2020. Estimates for SMI Parts B and D are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

### HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the next 16 years, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the trust fund, and other miscellaneous revenue. Expenditures include benefit payments and administrative expenses. The estimates are for the “open group” population—all persons who will participate during the period as either HI taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 16 years. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.

As chart 1 shows, HI expenditures exceeded income excluding interest in 2004 and, under the intermediate assumptions, would begin to exceed income including interest in 2012.



<sup>1</sup> Dollar amounts that are not adjusted for inflation or other factors are referred to as “nominal.”

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2012, the trust fund would start redeeming trust fund assets; by the end of 2020, the assets would be depleted—1 year later than estimated in the 2004 Trustees Report. For the second year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

The projected year of depletion of the trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.

By law, Medicare trust fund assets are invested in special U.S. Treasury Securities, which earn interest while Treasury uses those cash resources for other Federal purposes. During times of Federal “on-budget” surpluses, this process reduces the Federal debt held by the public. In times of Federal budget deficits, Medicare surpluses reduce the amount that must be borrowed from the public to finance those deficits. The trust fund assets are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing other Federal expenditures. (When the assets are financed by borrowing, the effect is to defer today's costs to later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries.) The existence of large trust fund balances, therefore, represents an important obligation of the Government to pay future Medicare benefits but does not necessarily make it easier for the Government to pay those benefits.

### SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the next 10 years, in nominal dollars. Whereas HI estimates are displayed through the year 2020, SMI estimates cover only the next 10 years, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not based on payroll taxes but rather on a combination of monthly beneficiary premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures.<sup>2</sup> Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 10 years.<sup>3</sup>

Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the States to the Part D account, and interest earned on the U.S. Treasury securities held by the trust fund.<sup>4</sup> Chart 2 displays only total income; it does not separately show income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.<sup>5</sup> Expenditures include benefit payments as well as administrative expenses.

<sup>2</sup> The Part D account also receives special payments from the States, representing a portion of their forgone Medicaid expenditures attributable to the new Medicare drug benefit.

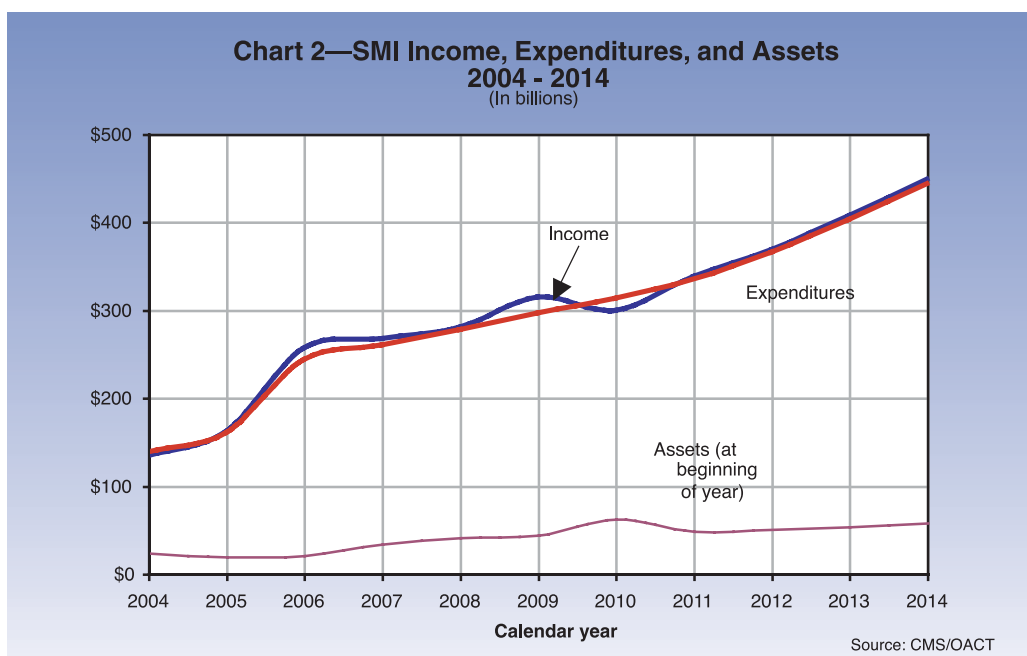
<sup>3</sup> Delivery of benefit checks normally due January 3, 2010 is expected to occur on December 31, 2009. Consequently, the Part B premiums withheld from the checks and the associated general revenue contributions are expected to be added to the Part B account on December 31, 2009. These amounts are excluded from the premium income and general revenue income for 2010.

<sup>4</sup> In the financial statements for CMS, Medicare income and expenditures are shown from a “trust fund perspective.” All sources of income to the trust funds are reflected, and the actuarial projections can be used to assess the financial status of each trust fund. Corresponding estimates for Medicare and other Federal social insurance programs are also shown in the annual *Financial Report of the United States Government*, also known as the consolidated financial statement. On a consolidated basis, the estimates are shown from a “Federal budget perspective.” In particular, certain categories of trust fund income—primarily interest payments and SMI general revenues—are excluded because they represent intragovernmental transfers, rather than revenues received from the public. Thus, the consolidated financial statement focuses not on the financial status of individual trust funds, but on the overall balance between revenues and outlays for the Federal budget. Each perspective is appropriate and useful for its intended purpose.

<sup>5</sup> Interest income is generally about 1 percent of total SMI income.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

As chart 2 indicates, SMI income is very close to expenditures. As mentioned earlier, this is because of the financing mechanism for Parts B and D. Under present law, both accounts are automatically in financial balance every year, regardless of future economic and other conditions.



It should be noted that the projected Part B expenditure and income growth is unrealistically low, due to the structure of physician payment updates under current law. This structure will result in multiple years of significant reductions in physician payments per service, though such reductions are very unlikely to occur before legislative changes intervene. But since these reductions are required under the current law payment system, they are reflected in this report. Consequently, the current law Part B projections shown are very likely to understate actual future expenditures in 2006 and later. Nevertheless, because of the financing mechanism for Part B, its income and expenditures will still be equivalent.

In addition to the inherent variability that underlies the cost projections prepared for all parts of Medicare, the Part D projections have an added uncertainty in that they were prepared for a new benefit, so there is no current program experience upon which to base the estimates. Accordingly, there is a very substantial level of uncertainty surrounding these cost projections.

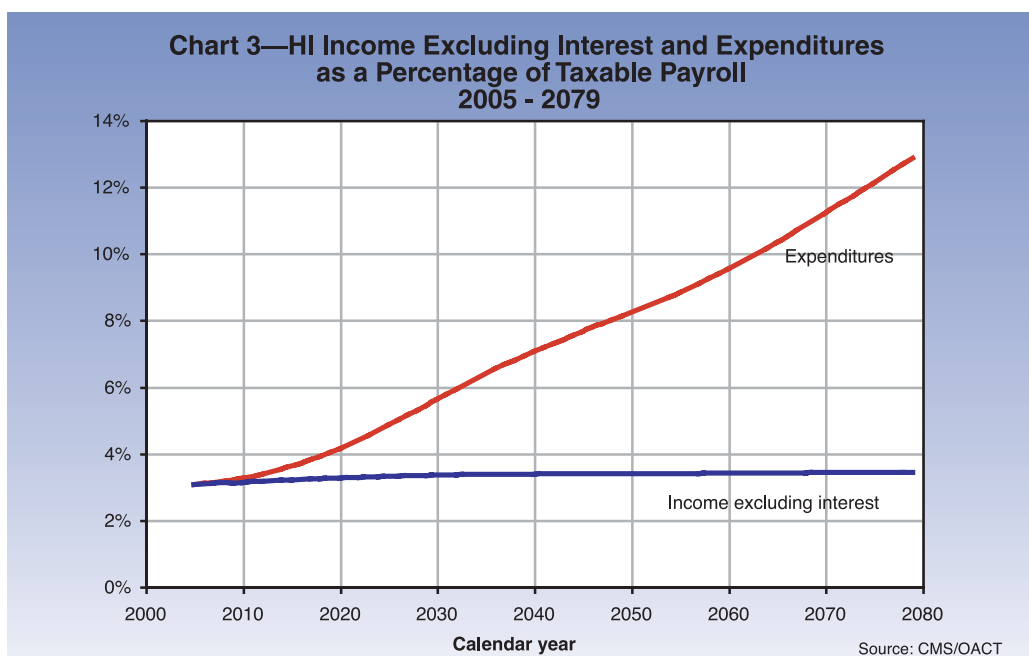
## HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. Because of the difficulty in meaningfully comparing dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as “taxable payroll”).

Chart 3 illustrates income (excluding interest) and expenditures, as a percentage of taxable payroll over the next 75 years. The long-range increase in average expenditures per beneficiary is assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point—reflecting an expectation that the impact of advances in medical technology on health care costs will continue, both in Medicare and in the health sector as a whole.

Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION



2.9 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percentage of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the attainment of Medicare eligibility of those born during the 1946-1964 baby boom.

### HI and SMI Cashflow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

#### HI

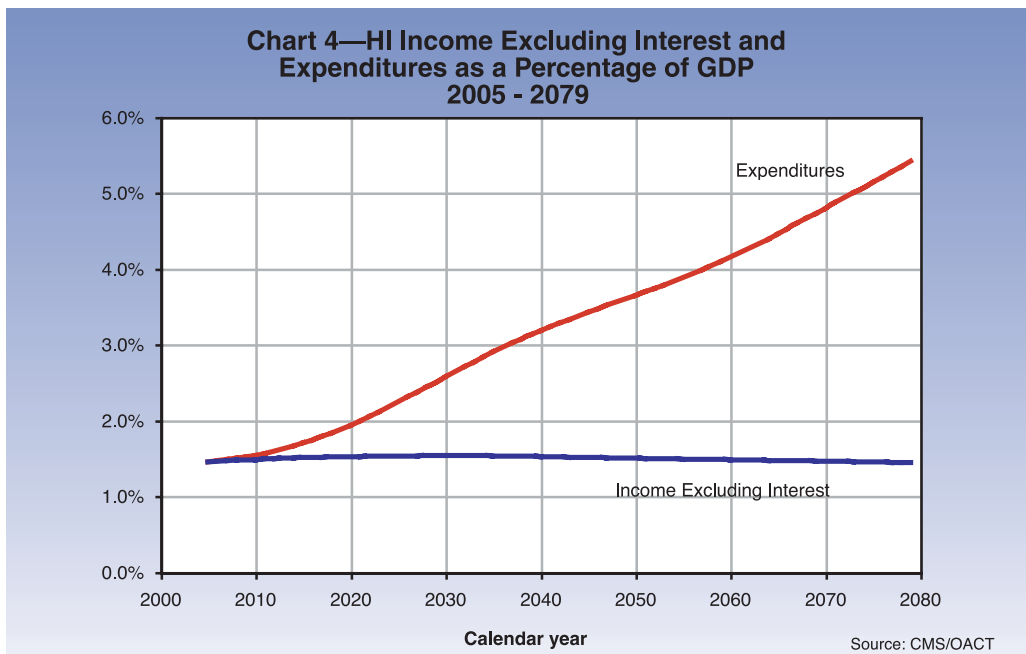
Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2004, the expenditures were \$170.6 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.

#### SMI

Because of the Part B and D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 5 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the long-range increase in average expenditures per beneficiary is assumed to equal growth in per capita GDP plus 1 percentage point. The growth rates are estimated year by year for the next 12 years,

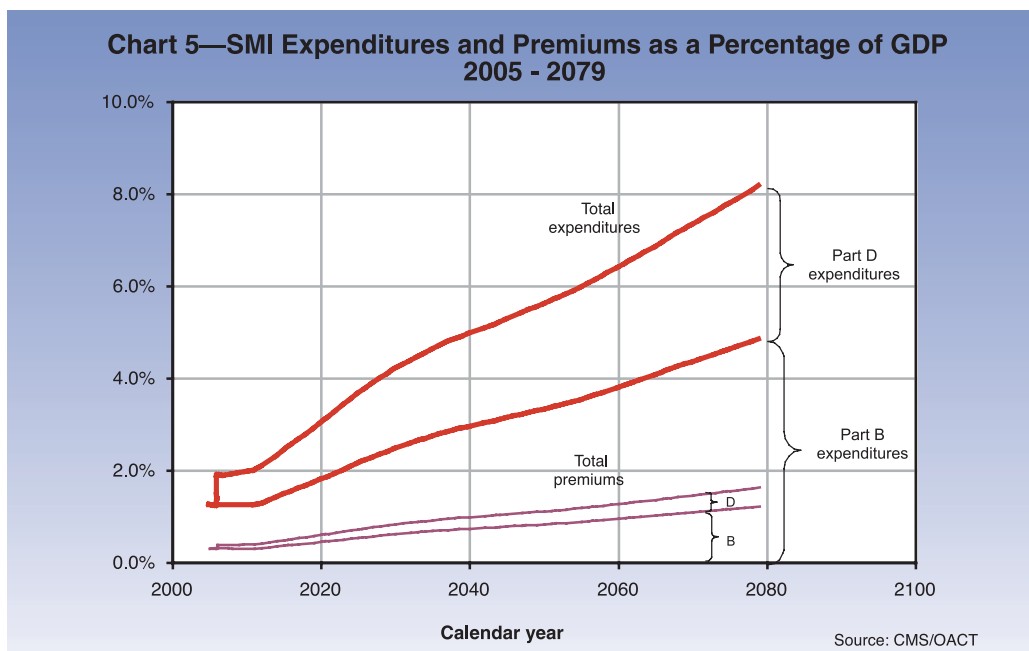
## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION



reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures would grow from about 1.2 percent of GDP in 2004 to 1.9 percent of GDP in 2006 with the commencement of the full prescription drug coverage. Then, within 25 years, they would grow to 4 percent of GDP and to more than 8 percent by the end of the projection period.

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact,



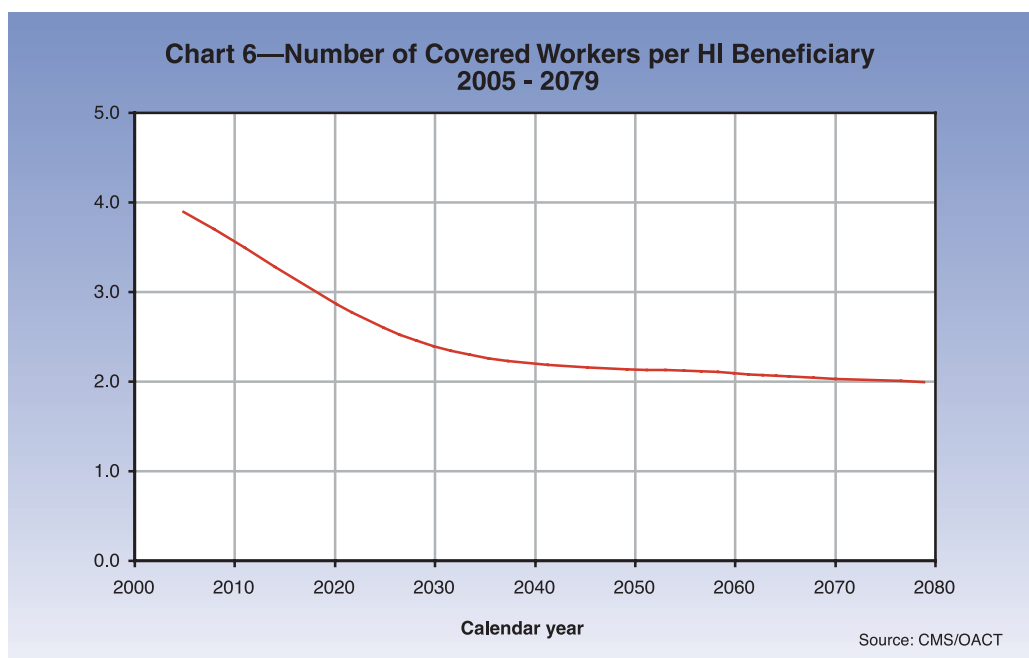
## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special state payments to the Part D account are set by law at a declining portion of the states' forgone Medicaid expenditures attributable to the new Medicare drug benefit. The percentage is 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the state payments are also expected to increase faster than GDP.

### Worker-to-Beneficiary Ratio

#### HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2004, every beneficiary had almost 4.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary in about 2055 and later.



## ACTUARIAL PRESENT VALUES

Projected future expenditures can be summarized by computing an “actuarial present value.” This value represents the lump-sum amount that, if invested today in trust fund securities, would be just sufficient to pay each year’s expenditures over the next 75 years, with the fund being drawn down to zero at the end of the period. Similarly, future revenues (excluding interest) can be summarized as a single, equivalent amount as of the current year.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Actuarial present values are calculated by discounting the future annual amounts of non-interest income and expenditures at the assumed rates of interest credited to the HI and SMI trust funds. Present values are computed as of the beginning of the 75-year projection period for three different groups of participants: current workers and other individuals who have not yet attained eligibility age; current beneficiaries who have attained eligibility age; and new entrants, or those who are expected to become participants in the future.

Table 1 sets forth, for each of these three groups, the actuarial present values of all future HI (Part A) and SMI (Part B and Part D) expenditures and all future non-interest income for the next 75 years. Also shown is the net present value of cashflow, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. Present values are shown (where available) based on each of the last five Trustees Reports. For each year shown, the present values are calculated as of January 1 of that year.

As shown in table 1, the HI trust fund has an actuarial deficit<sup>6</sup> of almost \$8.6 trillion over the 75-year projection period, as compared to about \$8.2 trillion in the *CMS 2004 Financial Report*. On the other hand, neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its financing mechanism.<sup>7</sup>

The existence of a large actuarial deficit for the HI trust fund indicates that, under reasonable assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures in the long range. Although the deficits are not anticipated in the immediate future, as indicated by the preceding cash-flow projections, they nonetheless pose a serious financial problem for the HI trust fund.

A figure as large as \$8.6 trillion can be difficult to interpret without some relative basis of comparison. To put this number in perspective, it is helpful to consider that the present value of future taxable payroll over the same 75-year period is estimated to be \$286 trillion in the 2005 Trustees Report. Thus, the \$8.6-trillion deficit represents approximately 3.0 percent of future taxable payroll.

As indicated in table 1, there has been substantial growth in the present values from one valuation period to the next. Much of this growth, however, is attributable to using a new valuation period each year.<sup>8</sup> The remainder reflects any changes in assumptions, methods, and/or base-year data that have been incorporated into the estimates. The impact of the changing valuation period can be largely eliminated by using the relative estimates. As indicated in the table, the 75-year actuarial deficit has increased from 1.97 percent of taxable payroll in the 2001 Trustees Report to 3.09 percent in the most recent report.

It is important to note that no liability has been recognized on the balance sheet for future payments to be made to current and future program participants beyond the existing “incurred but not reported” Medicare claim amounts as of September 30, 2005. This is because Medicare is accounted for as a social insurance program rather than a

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<sup>6</sup> Present value of estimated future income less expenditures, calculated over the 75-year projection period, plus start-of-period assets.

<sup>7</sup> As noted in footnote 4 on page 61, the actuarial deficit is calculated from a *trust fund perspective*, reflecting all sources of income and expenditures to or from the HI and SMI trust funds. If, instead, a *budget perspective* is considered, as used in the consolidated financial statement, one would compare Medicare outlays to the public with revenues received directly from the public and State governments. On this basis, transfers to the SMI trust fund from the general fund of the Treasury would be excluded, with the result that the present value of projected SMI expenditures through 2079 would exceed the present value of projected SMI premium and State transfer revenue by \$21.1 trillion. When added to the corresponding differential for HI, the present value of expenditures for the Medicare program overall is projected to exceed non-general revenue receipts by \$30.0 trillion. This theoretical *budget impact* reflects both (i) the cost to the Federal budget of SMI general revenues provided under current law and (ii) the amount that HI revenues would have to be increased to enable HI benefits to be paid at their currently scheduled level—for which there is no provision in current law.

<sup>8</sup> The present values of income and expenditures, from one valuation period to the next, tend to increase by the growth in average wages and benefits, respectively. The present value of income less expenditures tends to increase by the interest rate plus the addition of a new 75th year difference between income and expenditures.

# REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

**TABLE 1**  
**Actuarial Present Values of Hospital Insurance and**  
**Supplementary Medical Insurance Revenues and Expenditures:**  
**75-year Projection as of January 1, 2005 and Prior Base Years**  
*(In billions)*

	HI					Part B					SMI <sup>2</sup>					Part D				
	2005	2004	2003	2002	2001	2005	2004	2003	2002	2001	2005	2004	2003	2002	2001	2005	2004	2003	2002	2001
<b><i>Actuarial present value<sup>1</sup> of estimated future income (excluding interest) received from or on behalf of:</i></b>																				
Current participants <sup>3</sup> who, at start of projection period:																				
Have not yet attained eligibility age (ages 15-64)	\$5,064	\$4,820	\$4,510	\$4,408	\$4,136	\$11,477	\$10,505	\$8,796	\$7,423	\$7,378	\$7,895	\$7,545	—	—	—					
Have attained eligibility age (age 65 and over)	162	148	128	125	113	1,436	1,310	1,160	1,008	1,032	817	713	—	—	—					
Those expected to become participants (under age 15)	4,209	4,009	3,773	3,733	3,507	3,658	3,514	2,817	2,402	2,370	2,522	2,511	—	—	—					
All current and future participants	9,435	8,976	8,411	8,286	7,757	16,571	15,329	12,773	10,833	10,780	11,233	10,770	—	—	—					
<b><i>Actuarial present value<sup>1</sup> of estimated future expenditures<sup>4</sup> paid to or on behalf of:</i></b>																				
Current participants <sup>3</sup> who, at start of projection period:																				
Have not yet attained eligibility age (ages 15-64)	12,668	12,054	10,028	9,195	8,568	11,541	10,577	8,845	7,463	7,415	7,913	7,566	—	—	—					
Have attained eligibility age (age 65 and over)	2,179	2,168	1,897	1,747	1,693	1,622	1,475	1,306	1,132	1,159	880	773	—	—	—					
Those expected to become participants (under age 15)	3,417	3,246	2,653	2,470	2,225	3,408	3,277	2,622	2,238	2,206	2,440	2,431	—	—	—					
All current and future participants	18,264	17,468	14,577	13,412	12,487	16,571	15,329	12,773	10,833	10,780	11,233	10,770	—	—	—					
<b><i>Actuarial present value<sup>1</sup> of estimated future income (excluding interest) less expenditures</i></b>																				
Trust fund assets at start of period	-8,829	-8,492	-6,166	-5,126	-4,730	0	0	0	0	0	0	0	—	—	—					
<b><i>Assets at start of period plus actuarial present value<sup>1</sup> of estimated future income (excluding interest) less expenditures</i></b>																				
HI actuarial present value of estimated future taxable payroll	-8,561	-8,236	-5,931	-4,917	-4,553	19	24	34	41	44	0	0	—	—	—					
<b><i>Assets plus actuarial present value of future income less expenditures as a percent of future taxable payroll (HI "actuarial balance")</i></b>																				
	286,019	272,352	256,370	254,065	240,971	n/a	n/a	n/a	n/a	n/a	n/a	n/a	—	—	—					
	3.09%	3.12%	2.40%	2.02%	1.97%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	—	—	—					

<sup>1</sup> Present values are computed on the basis of the intermediate set of economic and demographic assumptions specified in the Report of the Boards of Trustees for the year shown and over the 75-year projection period beginning January 1 of that year.

<sup>2</sup> SMI income includes premiums paid by beneficiaries and general revenue contributions made on behalf of beneficiaries. Transfers from State governments are also included as income for Part D of SMI. See footnote 4 on page 61 concerning treatment of SMI general revenues in the consolidated financial statement of the U.S. Government.

<sup>3</sup> Current participants are the "closed group" of individuals age 15 and over at the start of each period, although not all those older than 15 have yet participated. The projection period consists of 75 years, a period that covers most of the participants' working and retirement years. As a practical matter, the present values of future income and expenditures from/for current participants beyond 75 years are not material to this calculation. The projection period for new entrants covers the next 75 years.

<sup>4</sup> Expenditures include benefit payments and administrative expenses.

Note: Totals do not necessarily equal the sums of rounded components.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

pension program. Accounting for a social insurance program recognizes the expense of benefits when they are actually paid, or are due to be paid, because benefit payments are primarily nonexchange transactions and, unlike employer-sponsored pension benefits for employees, are not considered deferred compensation. Accrual accounting for a pension program, by contrast, recognizes retirement benefit expenses as they are earned so that the full actuarial present value of the worker's expected retirement benefits has been recognized by the time the worker retires.

## ACTUARIAL ASSUMPTIONS AND SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that the trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions, including changes in per beneficiary cost, wages and the consumer price index (CPI), fertility rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period.

Table 2 shows the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. Further details on these assumptions are available in the Social Security and Medicare Trustees Reports for 2005. In practice, a number of specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The per beneficiary cost increases displayed in table 2 reflect the overall impact of these more detailed assumptions.

**TABLE 2**  
**Medicare Assumptions**

	<i>Annual percentage change in:</i>									
	Fertility rate <sup>1</sup>	Net immigration	Real-wage differential <sup>2</sup>	Wages	CPI	Real GDP	Per beneficiary cost <sup>3</sup>			Real-interest rate <sup>4</sup>
							HI	SMI	D	
								B		
2005	2.02	1,075,000	2.1	4.2	2.2	3.6	5.4	6.6	—	2.0
2010	2.01	1,000,000	1.3	4.1	2.8	2.5	4.3	3.2	7.0	2.9
2020	1.98	950,000	1.1	3.9	2.8	1.9	4.3	5.4	6.5	3.0
2030	1.95	900,000	1.1	3.9	2.8	1.8	5.5	5.2	4.9	3.0
2040	1.95	900,000	1.1	3.9	2.8	1.9	5.7	5.2	5.1	3.0
2050	1.95	900,000	1.1	3.9	2.8	1.8	5.1	5.0	5.1	3.0
2060	1.95	900,000	1.1	3.9	2.8	1.8	5.2	5.2	5.1	3.0
2070	1.95	900,000	1.1	3.9	2.8	1.8	5.3	5.1	5.1	3.0
2079	1.95	900,000	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0

<sup>1</sup> Average number of children per woman.

<sup>2</sup> Difference between percentage increases in wages and the CPI.

<sup>3</sup> See text for nature of this assumption.

<sup>4</sup> Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Estimates made in prior years have sometimes changed substantially because of revisions to the assumptions, which are due either to changed conditions or to more information. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty. In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values and net cashflows.<sup>9</sup> The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, CPI, and real-interest rate.<sup>10</sup>

For this analysis, the intermediate economic and demographic assumptions in the *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2005 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2020 under all three scenarios displayed. On the present value charts, the same pattern is evident, though the magnitudes are lower because of the discounting process used for computing present values.

### Health Care Cost Factors

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

**TABLE 3**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Health Care Cost Growth Rate Assumptions**

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures ( <i>in billions</i> )	-\$3,140	-\$8,829	-\$18,113

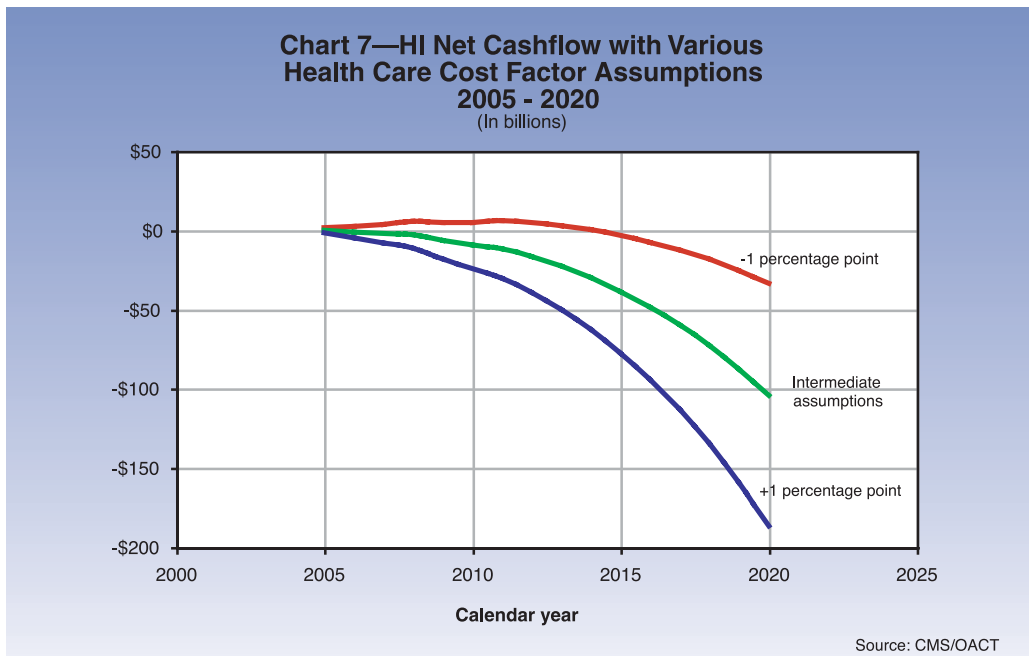
Table 3 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income versus expenditures decreases by \$5,689 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by \$9,284 billion.

<sup>9</sup> Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to its financing mechanism for each account. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

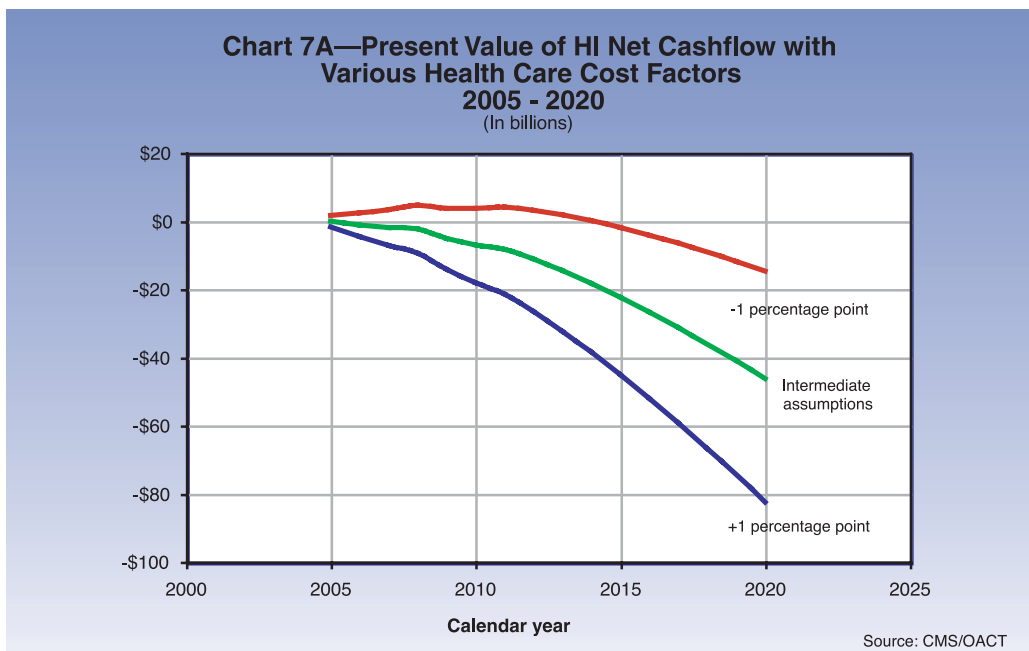
<sup>10</sup> The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Charts 7 and 7A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 3.



This assumption has a dramatic impact on projected HI cashflow. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As charts 7 and 7A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.



## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

### Fertility Rate

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 1.95, and 2.2 children per woman.

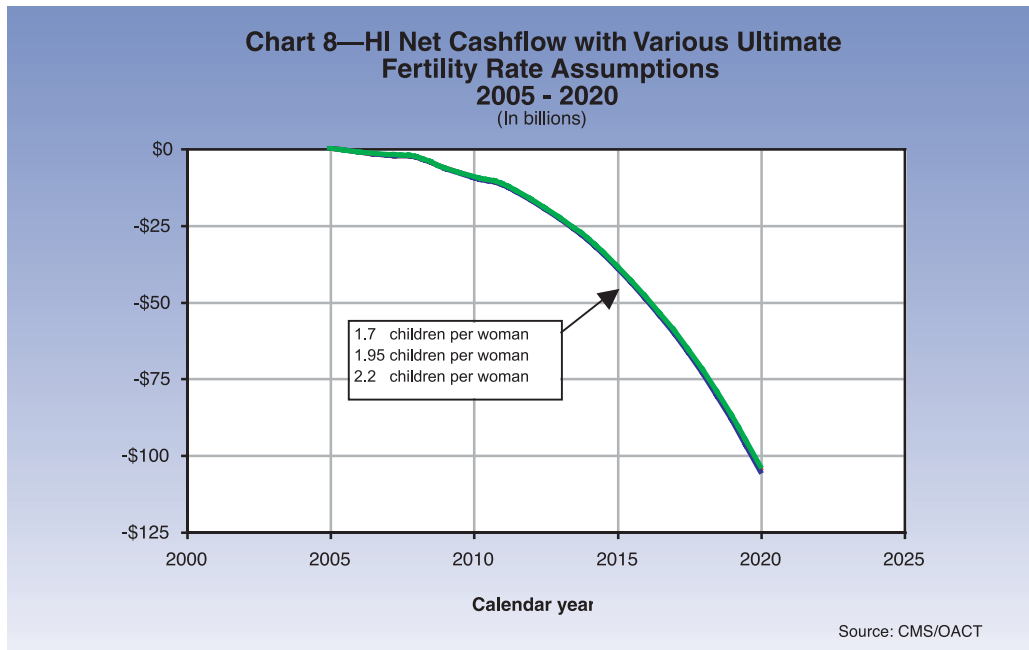
**TABLE 4**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Fertility Rate Assumptions**

Ultimate fertility rate <sup>1</sup>	1.7	1.95	2.2
Income minus expenditures (in billions)	-\$8,978	-\$8,829	-\$8,677

<sup>1</sup> The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

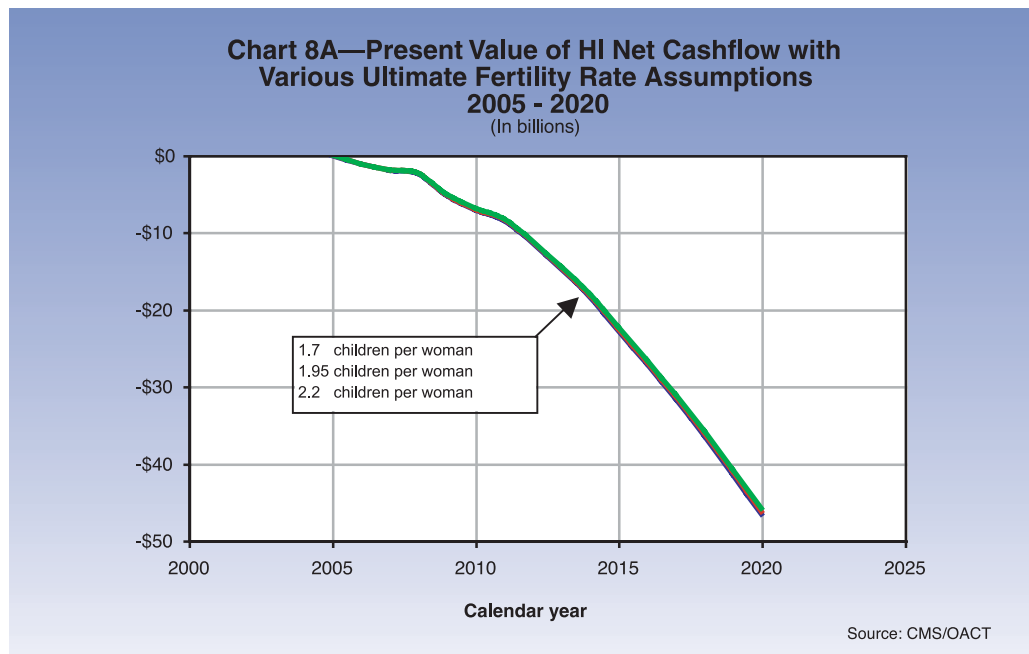
As table 4 demonstrates, for an increase of 0.25 in the assumed ultimate fertility rate, the projected deficit decreases by approximately \$150 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 4.



As charts 8 and 8A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows over the next 16 years. In fact, higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the impacts are expected to be somewhat greater, as illustrated by the present values in table 4.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION



## Net Immigration

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

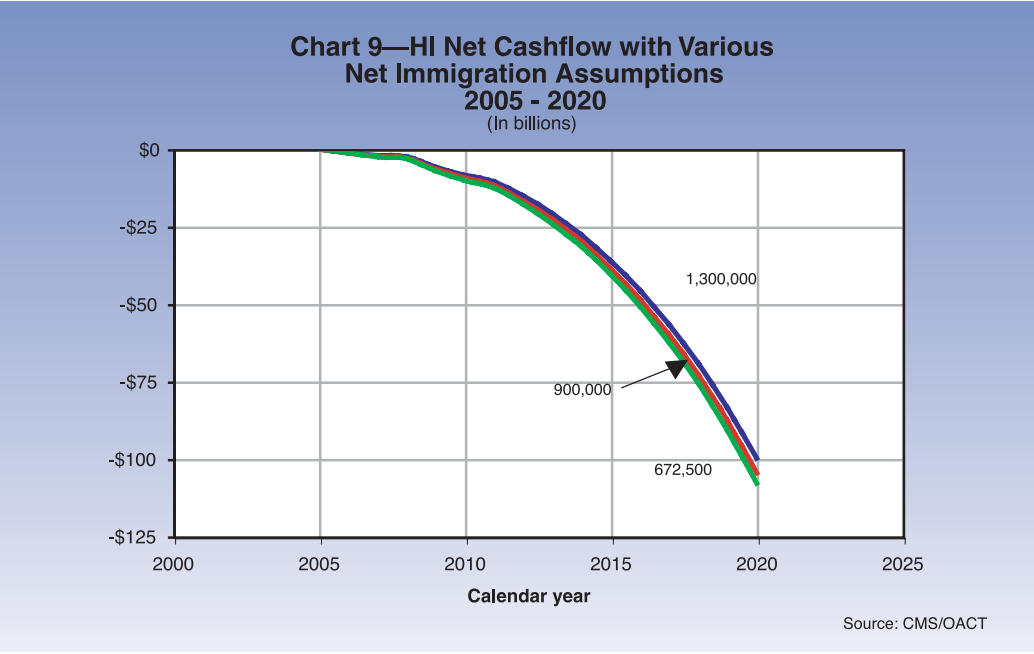
**TABLE 5**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Net Immigration Assumptions**

Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures	-\$8,734	-\$8,829	-\$8,982
<i>(in billions)</i>			

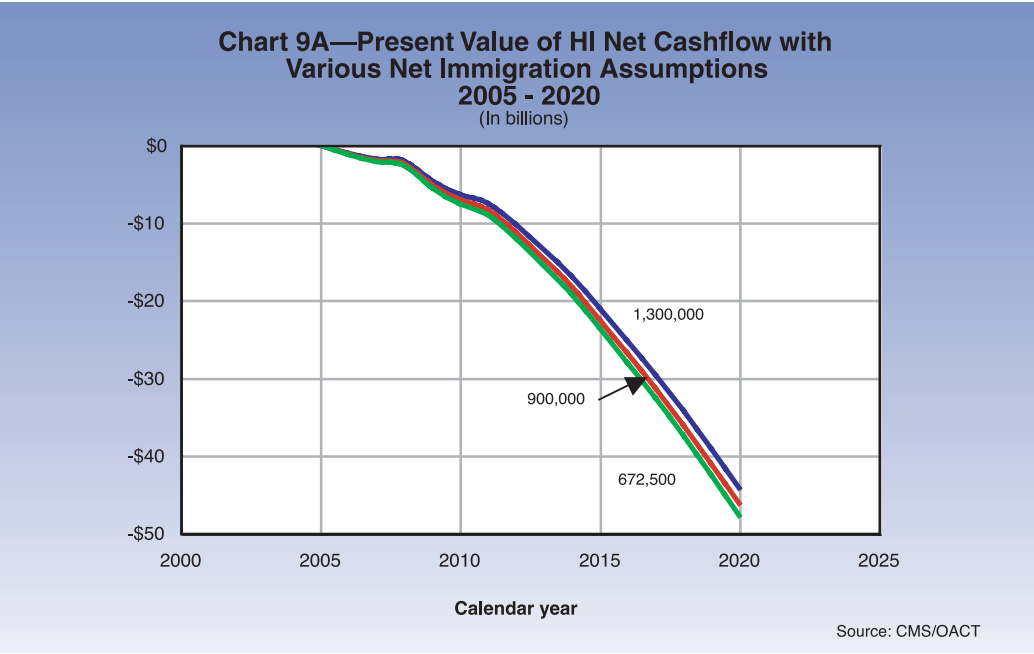
As shown in table 5, if the ultimate net immigration assumption is 672,500 persons, the deficit of income versus expenditures decreases by \$95 billion. Similarly, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases by \$153 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 5.

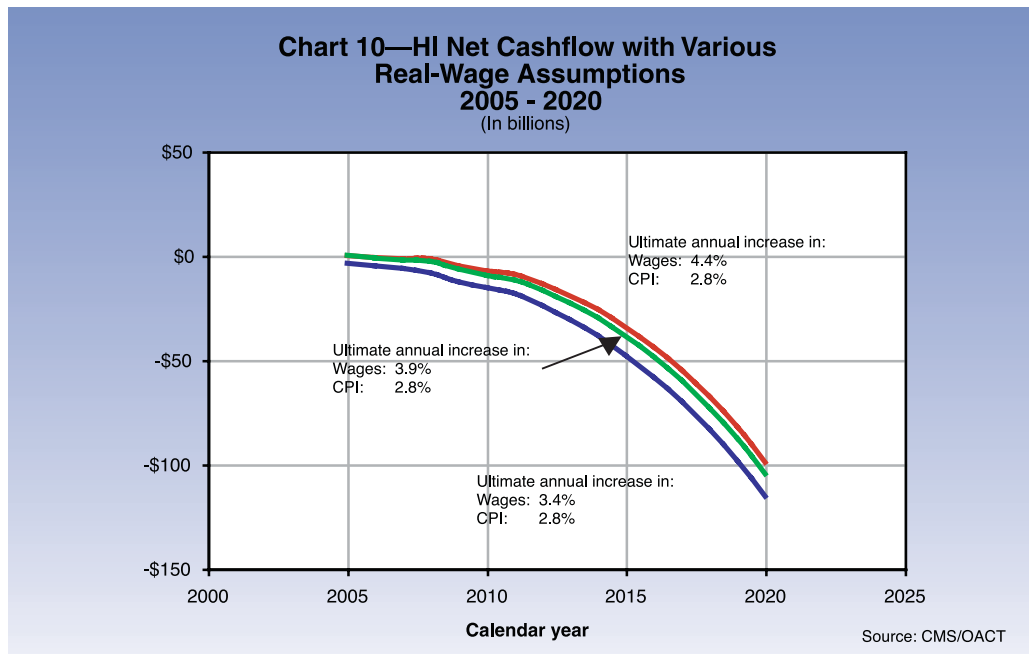
**REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION**



As charts 9 and 9A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among those who work and pay taxes into the system, in the short term payroll taxes increase faster than benefits; in the long term, however, the opposite occurs, as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.



## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION



### Real-Wage Differential

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential<sup>11</sup> assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

**TABLE 6**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Real-Wage Assumptions**

Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures ( <i>in billions</i> )	-\$8,303	-\$8,829	-\$9,531

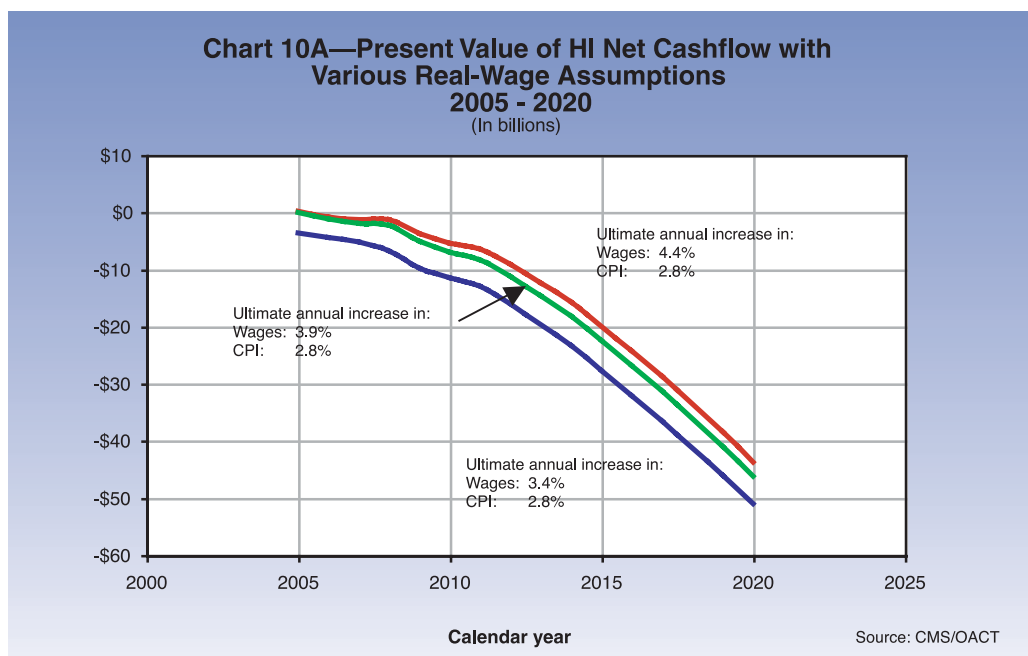
As indicated in table 6, for a half-point increase in the ultimate real-wage differential assumption, the deficit decreases by approximately \$600 billion.

Charts 10 and 10A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 6.

As charts 10 and 10A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential assumptions

<sup>11</sup> The difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION



immediately increase both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage-related.

### Consumer Price Index

Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

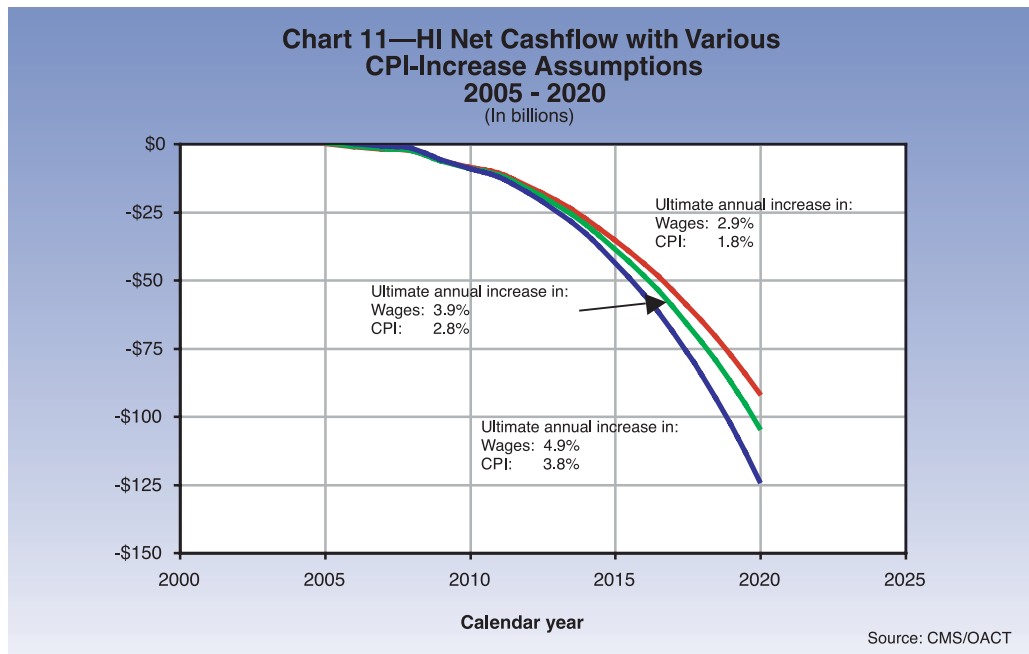
**TABLE 7**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various CPI-Increase Assumptions**

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures ( <i>in billions</i> )	-\$8,863	-\$8,829	-\$8,751

Table 7 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by \$34 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by \$78 billion.

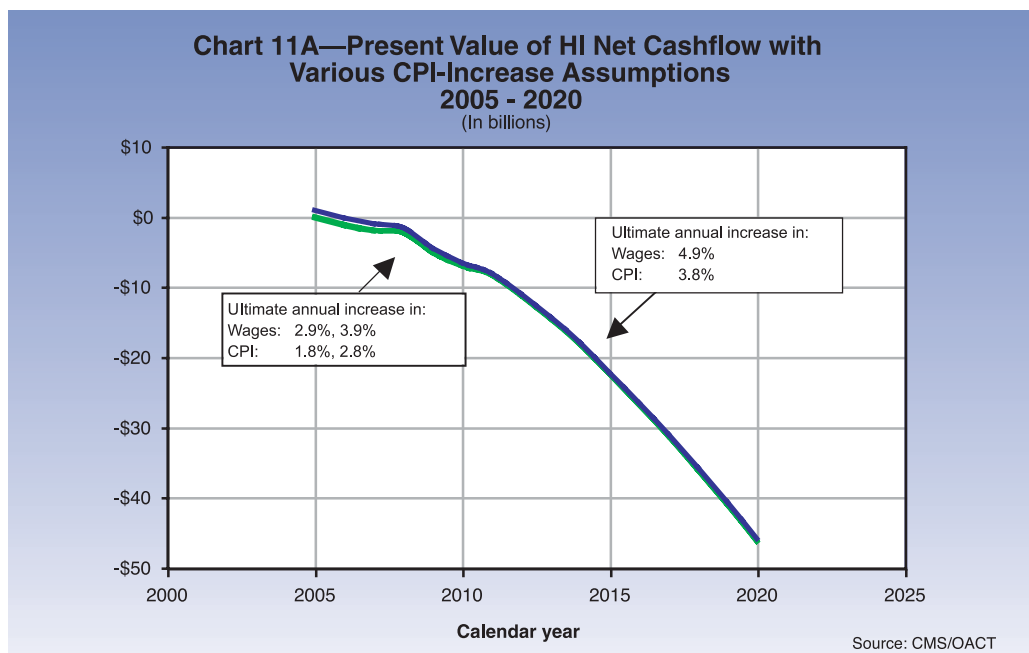
Charts 11 and 11A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 7.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION



As charts 11 and 11A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values.

The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In nominal dollars, however, a given deficit “looks bigger” under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.



## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

### Real-Interest Rate

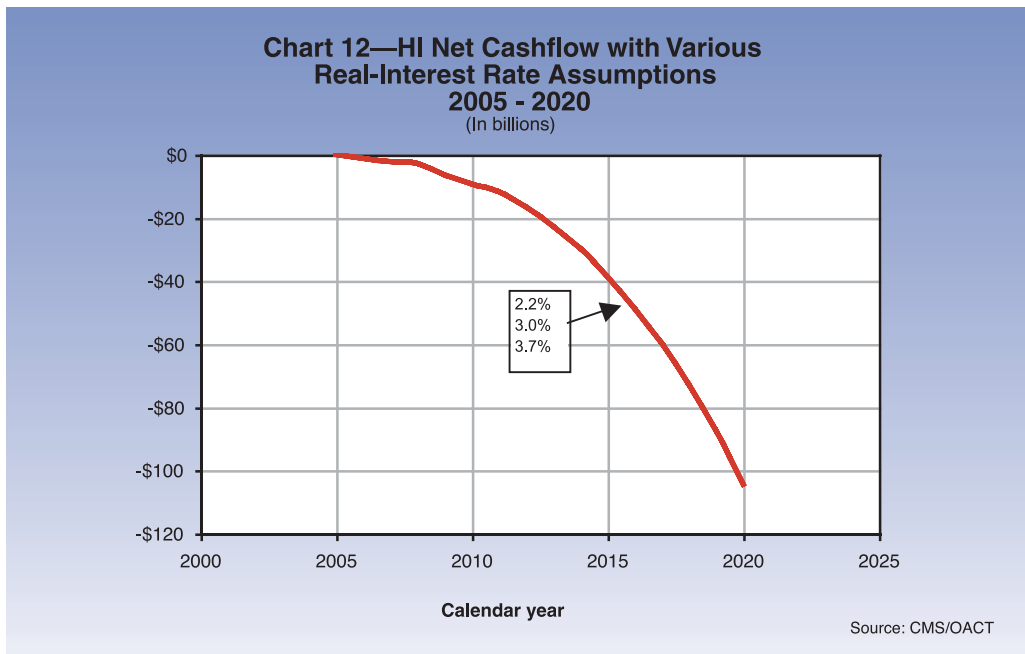
Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.2, 3.0, and 3.7 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 5.0, 5.8, and 6.5 percent, respectively.

**TABLE 8**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Real-Interest Assumptions**

Ultimate real-interest rate	2.2 percent	3.0 percent	3.7 percent
Income minus expenditures (in billions)	-\$12,075	-\$8,829	-\$6,544

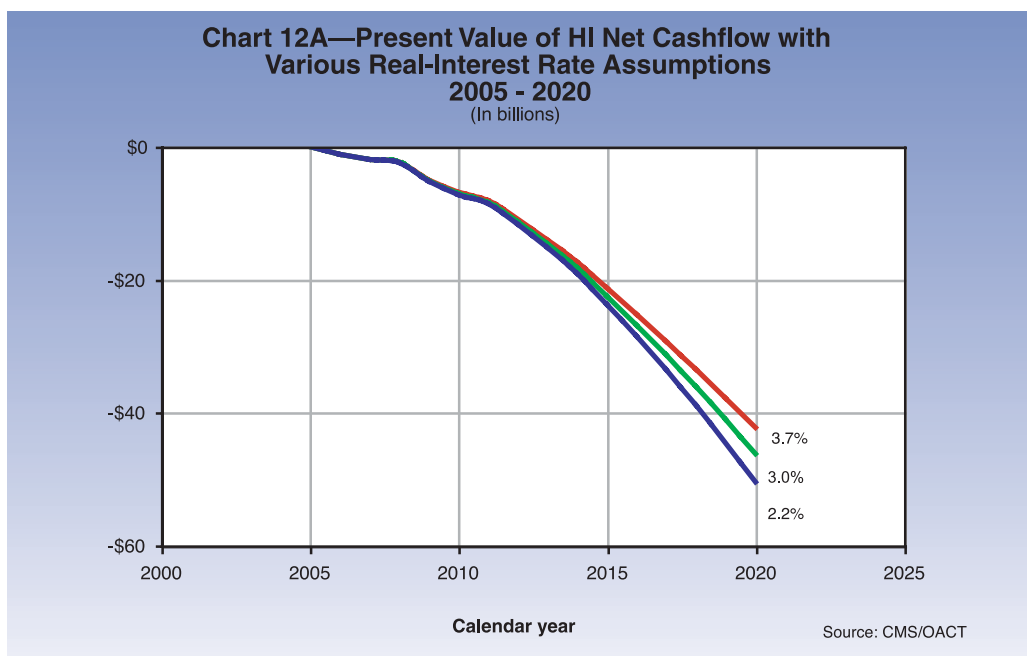
As illustrated in table 8, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately \$370 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 8.



As shown in charts 12 and 12A, the present values of the net cashflow are more sensitive to the interest assumption than is the nominal net cashflow. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION



finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2020. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

## TRUST FUND FINANCES AND SUSTAINABILITY



Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2020, 1 year later than in last year's report, due primarily to slightly higher income and slightly lower costs in 2004 than previously estimated. Despite the slight improvement, income from all sources is projected to continue to exceed expenditures for only the next 7 years and to fall short by steadily increasing amounts in 2012 and later. These shortfalls can be met with increasing reliance on interest payments on invested assets and the redemption of those assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted trust fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

The HI trust fund is substantially out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require very substantial increases in revenues and/or reductions in benefits. These changes are needed in part as a result of the impending retirement of the baby boom generation.

### SMI

Under current law, the SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. Because there is no authority to transfer assets between the new Part D account and the existing Part B account, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2005 is estimated to be sufficient to cover expenditures for that year but not to increase assets to a more adequate contingency reserve. The Part B premium and corresponding general revenue transfers will need to be increased sharply for 2006 to match projected costs and to restore Part B assets to a more adequate reserve level.

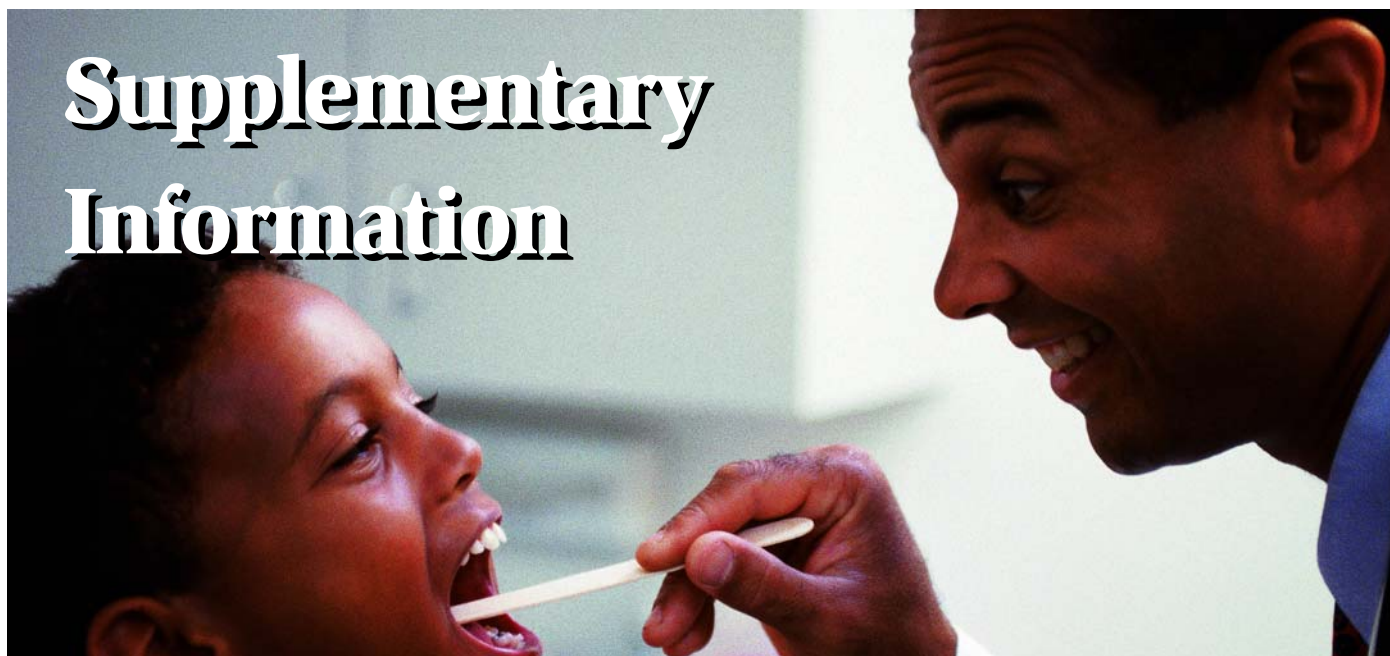
The operations of the Part D account in 2005 relate only to the transitional assistance benefit for low-income beneficiaries. No financial imbalance is anticipated, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. Potential variations in Part D costs in 2006 and later are expected to be handled through a flexible general revenue appropriations process, eliminating the need for a significant Part D contingency reserve.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. However, a critical issue for the trust fund is the impact of the past and expected rapid growth of SMI costs, which place steadily increasing demands on beneficiaries, the Federal budget, and society at large.

### Medicare Overall

The projections shown in this section continue to demonstrate the need for the Administration and the Congress to address the financial challenges facing Medicare—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures. In their 2005 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the Nation's policy makers to take “prompt, effective and decisive action...to address these challenges.” They also stated: “Consideration of such reforms should occur in the relatively near future.”

# Supplementary Information



## CONSOLIDATING BALANCE SHEET As of September 30, 2005 (in millions)

	MEDICARE			HEALTH			Combined	Intra-CMS	Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals	Eliminations	Totals
<b>ASSETS</b>									
<b>Intragovernmental Assets:</b>									
Fund Balance with Treasury	\$366	\$1,303	\$1,669	\$10,942	\$7,275	\$903	\$20,789		\$20,789
Trust Fund Investments	280,996	17,448	298,444				298,444		298,444
Accounts Receivable, Net	17,978	24,172	42,150	146	3	9	42,308	\$(41,854)	454
<b>Other Assets:</b>									
Anticipated Congressional Appropriation		5,173	5,173	9,099			14,272		14,272
<b>Total Intragovernmental Assets</b>	<b>299,340</b>	<b>48,096</b>	<b>347,436</b>	<b>20,187</b>	<b>7,278</b>	<b>912</b>	<b>375,813</b>	<b>(41,854)</b>	<b>333,959</b>
Cash & Other Monetary Assets	19	185	204				204		204
Accounts Receivable, Net	769	1,045	1,814	55		15	1,884		1,884
General Property, Plant & Equipment, Net	143	223	366	25	1		392		392
Other	2,195	1,971	4,166	6		29	4,201		4,201
<b>TOTAL ASSETS</b>	<b>\$302,466</b>	<b>\$51,520</b>	<b>\$353,986</b>	<b>\$20,273</b>	<b>\$7,279</b>	<b>\$956</b>	<b>\$382,494</b>	<b>\$(41,854)</b>	<b>\$340,640</b>
<b>LIABILITIES</b>									
<b>Intragovernmental Liabilities:</b>									
Accounts Payable	\$17,600	\$24,578	\$42,178				\$42,178	\$(41,854)	\$324
Accrued Payroll and Benefits	1	3	4				4		4
Other Intragovernmental Liabilities	117	291	408	\$3		\$22	433		433
<b>Total Intragovernmental Liabilities</b>	<b>17,718</b>	<b>24,872</b>	<b>42,590</b>	<b>3</b>		<b>22</b>	<b>42,615</b>	<b>(41,854)</b>	<b>761</b>
Federal Employee & Veterans' Benefits	3	6	9	1			10		10
Entitlement Benefits Due & Payable	16,806	16,593	33,399	20,105		250	53,754		53,754
Accrued Payroll & Benefits	17	32	49	5			54		54
Other Liabilities	1,168	751	1,919			7	1,926		1,926
<b>TOTAL LIABILITIES</b>	<b>35,712</b>	<b>42,254</b>	<b>77,966</b>	<b>20,114</b>		<b>279</b>	<b>98,359</b>	<b>(41,854)</b>	<b>56,505</b>
<b>NET POSITION</b>									
Unexpended Appropriations		6,873	6,873		\$7,275	558	14,706		14,706
Cumulative Results of Operations	266,754	2,393	269,147	159	4	119	269,429		269,429
<b>TOTAL NET POSITION</b>	<b>\$266,754</b>	<b>\$9,266</b>	<b>\$276,020</b>	<b>\$159</b>	<b>\$7,279</b>	<b>\$677</b>	<b>\$284,135</b>		<b>\$284,135</b>
<b>TOTAL LIABILITIES &amp; NET POSITION</b>	<b>\$302,466</b>	<b>\$51,520</b>	<b>\$353,986</b>	<b>\$20,273</b>	<b>\$7,279</b>	<b>\$956</b>	<b>\$382,494</b>	<b>\$(41,854)</b>	<b>\$340,640</b>

## SUPPLEMENTARY INFORMATION

### CONSOLIDATING STATEMENT OF NET COST For the Year Ended September 30, 2005 (in millions)

	MEDICARE			HEALTH			Combined	Intra-CMS	Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals	Eliminations	Totals
<b>NET PROGRAM/ACTIVITY COSTS</b>									
<b>GPRA Programs</b>									
Medicare	\$180,393	\$115,320	\$295,713				\$295,713		\$295,713
Medicaid				\$182,226			182,226		182,226
SCHIP					\$5,135		5,135		5,135
<b>NET COST—GPRA PROGRAMS</b>	<b>180,393</b>	<b>115,320</b>	<b>295,713</b>	<b>182,226</b>	<b>5,135</b>		<b>483,074</b>		<b>483,074</b>
<b>Other Activities</b>									
CLIA						\$3	3		3
Ticket to Work Incentive						325	325		325
<b>NET COST—OTHER ACTIVITIES</b>						<b>328</b>	<b>328</b>		<b>328</b>
<b>NET COST OF OPERATIONS</b>	<b>\$180,393</b>	<b>\$115,320</b>	<b>\$295,713</b>	<b>\$182,226</b>	<b>\$5,135</b>	<b>\$328</b>	<b>\$483,402</b>		<b>\$483,402</b>

### CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION For the Year Ended September 30, 2005 (in millions)

	HI	MEDICARE SMI	Total	Medicaid	HEALTH SCHIP	All Others	Consolidated Totals
<b>CUMULATIVE RESULTS OF OPERATIONS</b>							
<b>Beginning Balances</b>	\$253,259	\$2,293	\$255,552	\$153	\$3	\$123	\$255,831
<b>Budgetary Financing Sources:</b>							
Appropriations Used	9,380	115,200	124,580	181,640	5,130	324	311,674
Nonexchange Revenue	184,457	1,336	185,793				185,793
Transfers-in/out Without Reimbursement	40	(1,137)	(1,097)	589	6		(502)
<b>Other Financing Sources:</b>							
Transfers-in Without Reimbursement	1		1				1
Imputed Financing from Costs Absorbed by Others	10	21	31	3			34
<b>TOTAL FINANCING SOURCES</b>	<b>193,888</b>	<b>115,420</b>	<b>309,308</b>	<b>182,232</b>	<b>5,136</b>	<b>324</b>	<b>497,000</b>
<b>NET COST OF OPERATIONS</b>	<b>180,393</b>	<b>115,320</b>	<b>295,713</b>	<b>182,226</b>	<b>5,135</b>	<b>328</b>	<b>483,402</b>
<b>NET CHANGE</b>	<b>13,495</b>	<b>100</b>	<b>13,595</b>	<b>6</b>	<b>1</b>	<b>(4)</b>	<b>13,598</b>
<b>ENDING BALANCES</b>	<b>\$266,754</b>	<b>\$2,393</b>	<b>\$269,147</b>	<b>\$159</b>	<b>\$4</b>	<b>\$119</b>	<b>\$269,429</b>
<b>UNEXPENDED APPROPRIATIONS</b>							
<b>Beginning Balances</b>		\$7,750	\$7,750		\$8,323	\$349	\$16,422
<b>Budgetary Financing Sources:</b>							
Appropriations Received	9,380	116,900	126,280	\$180,141	4,082	536	311,039
Appropriations Transferred-out				(1,397)			(1,397)
Other Adjustments		(2,577)	(2,577)	2,896		(3)	316
Appropriations Used	(9,380)	(115,200)	(124,580)	(181,640)	(5,130)	(324)	(311,674)
<b>TOTAL FINANCING SOURCES</b>		<b>(877)</b>	<b>(877)</b>		<b>(1,048)</b>	<b>209</b>	<b>(1,716)</b>
<b>NET CHANGE</b>		<b>(877)</b>	<b>(877)</b>		<b>(1,048)</b>	<b>209</b>	<b>(1,716)</b>
<b>ENDING BALANCES</b>		<b>\$6,873</b>	<b>\$6,873</b>		<b>\$7,275</b>	<b>\$558</b>	<b>\$14,706</b>

## SUPPLEMENTARY INFORMATION

### COMBINING STATEMENT OF BUDGETARY RESOURCES For the Year Ended September 30, 2005

(in millions)

	HI	MEDICARE SMI	Payments to Trust Funds	Medicaid	SCHIP	All Others	Combined Totals
<b>Budgetary Resources:</b>							
Budget Authority:							
Appropriations received	\$197,429	\$153,540	\$126,280	\$180,141	\$4,082	\$1,629	\$663,101
Net transfers				(1,397)			(1,397)
Unobligated Balance:							
Beginning of period			2,105	5,911		3,160	11,176
Spending authority from offsetting collections:							
Earned:							
Collected	1					77	78
Change in unfilled customer orders:							
Without advance from Federal sources						(2)	(2)
Transfers from trust funds				315		2,605	2,920
<b>SUBTOTAL</b>	<b>1</b>			<b>315</b>		<b>2,680</b>	<b>2,996</b>
Recoveries of prior year obligations	16	26		9,642	643	230	10,557
Temporarily not available pursuant to Public Law	(11,175)	25					(11,150)
Permanently not available			(2,105)	(2,600)		(61)	(4,766)
<b>TOTAL BUDGETARY RESOURCES</b>	<b>\$186,271</b>	<b>\$153,591</b>	<b>\$126,280</b>	<b>\$192,012</b>	<b>\$4,725</b>	<b>\$7,638</b>	<b>\$670,517</b>
<b>Status of Budgetary Resources:</b>							
Obligations Incurred:							
Direct	\$186,271	\$153,591	\$124,580	\$191,695	\$4,725	\$6,476	\$667,338
Reimbursable						81	81
<b>SUBTOTAL</b>	<b>186,271</b>	<b>153,591</b>	<b>124,580</b>	<b>191,695</b>	<b>4,725</b>	<b>6,557</b>	<b>667,419</b>
Unobligated Balance:							
Apportioned			1,700			947	2,647
Unobligated Balance not available				317		134	451
<b>TOTAL STATUS OF BUDGETARY RESOURCES</b>	<b>\$186,271</b>	<b>\$153,591</b>	<b>\$126,280</b>	<b>\$192,012</b>	<b>\$4,725</b>	<b>\$7,638</b>	<b>\$670,517</b>
<b>Relationship of Obligations to Outlays:</b>							
Obligated Balance, net, beginning of period	\$16,090	\$15,979		\$9,315	\$8,323	\$617	\$50,324
Obligated Balance, net, end of period:							
Accounts receivable						(1,624)	(1,624)
Unfulfilled customer orders from Federal sources						(7)	(7)
Undelivered orders	365	103			7,276	1,759	9,503
Accounts payable	17,368	17,477		10,635		812	46,292
Outlays:							
Disbursements	184,612	151,964	\$124,580	\$180,733	5,129	6,073	653,091
Collections	(1)			(315)		(2,749)	(3,065)
<b>SUBTOTAL</b>	<b>184,611</b>	<b>151,964</b>	<b>124,580</b>	<b>180,418</b>	<b>5,129</b>	<b>3,324</b>	<b>650,026</b>
<b>LESS: OFFSETTING RECEIPTS</b>	<b>13,597</b>	<b>152,133</b>					<b>165,730</b>
<b>NET OUTLAYS</b>	<b>\$171,014</b>	<b>\$(169)</b>	<b>\$124,580</b>	<b>\$180,418</b>	<b>\$5,129</b>	<b>\$3,324</b>	<b>\$484,296</b>

## SUPPLEMENTARY INFORMATION

### GROSS COST AND EXCHANGE REVENUE For the Year Ended September 30, 2005 (in millions)

PROGRAM/ACTIVITY	INTRAGOVERNMENTAL						WITH THE PUBLIC		Consolidated Net Cost of Operations
	Gross Cost			Less: Exchange Revenue			Gross Cost	Less: Exchange	
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated			
<b>NET PROGRAM/ACTIVITY COSTS</b>									
<b>GPRA Programs</b>									
Medicare									
HI	\$380		\$380	\$4		\$4	\$182,327	\$2,310	\$180,393
SMI	167		167	6		6	151,098	35,939	115,320
Medicaid	26		26	1		1	182,201		182,226
SCHIP							5,135		5,135
<b>SUBTOTAL</b>	<b>573</b>		<b>573</b>	<b>11</b>		<b>11</b>	<b>520,761</b>	<b>38,249</b>	<b>483,074</b>
<b>Other Activities</b>									
CLIA	27		27				36	60	3
TWI							325		325
<b>SUBTOTAL</b>	<b>27</b>		<b>27</b>				<b>361</b>	<b>60</b>	<b>328</b>
<b>PROGRAM/ACTIVITY TOTALS</b>	<b>\$600</b>		<b>\$600</b>	<b>\$11</b>		<b>\$11</b>	<b>\$521,122</b>	<b>\$38,309</b>	<b>\$483,402</b>

### CONSOLIDATED INTRAGOVERNMENTAL BALANCES For the Year Ended September 30, 2005 (in millions)

		*TFM Dept. Code	Fund Bal. with Treasury	Investments	Accounts Receivable	Other
<b>INTRAGOVERNMENTAL ASSETS</b>						
<b>Agency</b>						
Department of the Treasury		20, 99	\$20,789	\$298,444		\$14,272
Railroad Retirement Board		60			\$454	
			<b>\$20,789</b>	<b>\$298,444</b>	<b>\$454</b>	<b>\$14,272</b>
<b>INTRAGOVERNMENTAL LIABILITIES</b>						
<b>Agency</b>				Environmental & Disposal Costs	Accrued Payroll & Benefits	Other
Department of Labor		16			\$2	
Department of the Treasury		20, 99				\$401
Office of Personnel Management		24			2	
Social Security Administration		28	\$296			
General Services Administration		47				5
Department of Health and Human Services		75	28			
All Other Federal Agencies						27
			<b>\$324</b>		<b>\$4</b>	<b>\$433</b>
<b>INTRAGOVERNMENTAL REVENUES &amp; EXPENSES</b>						
<b>Agency</b>			Earned Revenue	Gross Cost	Non-exchange Transfers-in	Revenue Transfers-out
Department of Commerce		13		\$4		
Department of Interior		14		2		
Department of Justice		15	\$3	115		
Department of Labor		16		1		
Department of the Treasury		20, 99		2	\$358	
Office of Personnel Management		24		96		
Social Security Administration		28			3	\$(1,239)
Department of Veterans Affairs		36	1			
General Services Administration		47		70		
Railroad Retirement Board		60			477	(7)
Environmental Protection Agency		68	2			
Department of Homeland Security		70		5		
Department of Health and Human Services		75	5	259		(84)
All Other Federal Agencies				46		(10)
			<b>\$11</b>	<b>\$600</b>	<b>\$838</b>	<b>\$(1,340)</b>

\* Treasury Financial Manual



Department of Health and Human Services

# **CENTERS FOR MEDICARE & MEDICAID SERVICES**





DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV - 7 2005

TO: Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*  
Inspector General

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare  
& Medicaid Services for Fiscal Year 2005 (A-17-05-02005)

This memorandum transmits the independent auditors' reports on the fiscal year 2005 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations of the Centers for Medicare & Medicaid Services (CMS). The CMS audit supports the Department of Health and Human Services audit, as required by the Chief Financial Officers Act of 1990 (Public Law 101-576), as amended.

We contracted with the independent certified public accounting (CPA) firm of PriceWaterhouseCoopers, LLP (PwC), to audit the CMS financial statements, with the exception of the CMS health programs, as of September 30, 2005 and 2004, and for the fiscal years then ended. We contracted with the independent CPA firm of Ernst and Young, LLP (hereafter referred to as other auditors) to audit the financial statements of the CMS health programs as of September 30, 2005, and for the fiscal year then ended. PwC's opinion expressed on the CMS financial statements, insofar as it relates to the amounts included for the health programs, is based solely on the report of the other auditors. The contracts required that the audits be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and OMB Bulletin 01-02, Audit Requirements for Federal Financial Statements.

#### Results of Independent Audit

Based on its audit and the report of the other auditors, PwC found that the fiscal years 2005 and 2004 CMS consolidated/combined financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. However, during testing of internal controls as of September 30, 2005, PwC noted certain matters involving internal controls over financial reporting that were reportable, of which one was deemed to be a material weakness under standards issued by the American Institute of Certified Public Accountants. Specifically, PwC reported a significant weakness regarding CMS's managed care benefits payment cycle.

CMS lacks a comprehensive control environment related to the managed care benefits payment cycle, including oversight of Medicare Advantage Organizations and demonstration projects. CMS implemented the Medicare Managed Care System despite known deficiencies in the system that led to erroneous payments. In addition, CMS failed to establish a process to ensure that accounting as well as operational issues were addressed throughout the new payment system implementation process. While the majority of these payments have been identified and corrected, existing policies and procedures are not sufficient to adequately reduce the risk of material benefit payment errors from occurring and not being detected and corrected in a timely manner.

Exclusive of the Federal Financial Management Improvement Act of 1996 and the Improper Payments Information Act of 2002, PwC disclosed no instances of noncompliance that are required to be reported under “Government Auditing Standards” and OMB Bulletin 01-02.

### **Evaluation and Monitoring of Audit Performance**

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audits;
- attending key meetings with auditors and CMS officials;
- monitoring the progress of the audits;
- examining audit documentation related to the review of internal controls over financial reporting;
- reviewing the auditors’ reports; and
- reviewing the CMS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

PwC is responsible for the attached auditors’ reports dated November 7, 2005, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS’s financial statements, the effectiveness of internal controls, whether CMS’s financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which PwC did not comply, in all material respects, with generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at [Joseph.Vengrin@oig.hhs.gov](mailto:Joseph.Vengrin@oig.hhs.gov). Please refer to report number A-17-05-02005 in all correspondence.

Attachment

cc:

Charles E. Johnson

Assistant Secretary for Budget, Technology, and Finance

Terry Hurst

Acting Deputy Assistant Secretary, Finance

## Report of Independent Auditors

To the Administrator of the Centers for Medicare and Medicaid Services and  
the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2005 and 2004, and the related consolidated statements of net cost, changes in net position and financing, and the combined statements of budgetary resources for the years then ended. These financial statements are the responsibility of CMS's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We did not audit the financial statements of the Health Programs which are a major subset of the CMS administered programs, which statements reflect total combined assets of \$28,508 and \$28,346 million and total combined net costs of \$187,689 and \$181,709 million, as of and for the years ended September 30, 2005 and 2004. Those statements and financial information were audited by other auditors whose reports thereon have been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for the Health Programs, is based solely on the reports of the other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits and the reports of other auditors provide a reasonable basis for our opinion.

In our opinion, based on our audits and the reports of other auditors, the consolidated and combined financial statements referred to above, present fairly, in all material respects, the financial position of CMS and its components as of September 30, 2005 and 2004, and their net cost, changes in net position, budgetary resources, and reconciliation of net cost to budgetary resources for the years then ended in conformity with accounting principles generally accepted in the United States of America.



## Report of Independent Auditors

As discussed in Note 1 to the financial statements, the Office of Management and Budget has exempted CMS from certain requirements of OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget*. Specifically, for the Medicare program, CMS is exempted from reporting recoveries of prior year obligations on the statement of budgetary resources.

Our audit was conducted for the purpose of forming an opinion on the consolidated and combined financial statements of CMS and its components taken as a whole. The supplementary information, which includes the required combining statement of budgetary resources and the consolidating financial statements, is presented for purposes of additional analysis and is not a required part of the consolidated and combined financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, are fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The Management's Discussion and Analysis (MD&A), Required Supplementary Information (RSI) and Required Supplementary Stewardship Information (RSSI) are not a required part of the financial statements but are supplementary information required by the Federal Accounting Standards Advisory Board and OMB Circular A-136, *Financial Reporting Requirements*. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the MD&A, RSI and RSSI. However, we did not audit the information and express no opinion on it.

The other accompanying information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued a report dated November 7, 2005 on our consideration of CMS's internal control and a report dated November 7, 2005 on its compliance and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audits.

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November 7, 2005

## Report of Independent Auditors on Compliance and Other Matters

To the Administrator of the Centers for Medicare and Medicaid Services and  
the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2005 the related consolidated statements of net cost, changes in net position and financing, and the combined statements of budgetary resources for the years then ended and issued our report thereon dated November 7, 2005. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*.

We did not audit the financial statements of the Health Programs which are a major subset of the CMS administered programs, which statements reflect total combined assets of \$28,508 and total combined net costs of \$187,689 million, as of and for the year ended September 30, 2005. Those statements and financial information were audited by other auditors whose report thereon has been furnished to us, and our report on CMS's compliance and other matters, insofar as it relates to the Health Programs, is based solely on the report of the other auditors.

The management of CMS is responsible for compliance with laws and regulations. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the compliance with certain provisions of laws and regulations, non-compliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to CMS. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion.

The results of our tests and other auditors' tests of CMS's compliance with laws and regulations, described in the preceding paragraph, exclusive of FFMIA or other matters that



## Report of Independent Auditors on Internal Control

are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 01-02, resulted in one instance of non-compliance as described below.

CMS has begun to implement the requirements of the Improper Payments Information Act of 2002 (IPIA). Although CMS has not complied with IPIA, CMS has implemented a process that measures the payment accuracy rates for the Medicare fee-for-service program.

Under FFMIA, we are required to report whether CMS's financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. The results of our tests disclosed instances, noted below, where CMS's financial management systems did not substantially comply with Federal financial management systems requirements and the U.S. Government Standard General Ledger at the transaction level.

In our report on internal control dated November 7, 2005, we reported a material weakness related to the Managed Care Benefits Payment Cycle and three reportable conditions (of which one related to the Health Programs and is based solely on the report of the other auditors referred to in the second paragraph of this report) related to the Lack of an Integrated Financial Management System and Medicare Electronic Processing Access Controls and Application Software Development and Change Control. We believe that these matters, taken together, represent substantial non-compliance with the Federal financial management system requirements under FFMIA. In addition, though operational at four Medicare Contractors, CMS has not yet completed the implementation of the HIGLAS general ledger system and as a result is not compliant with the U.S. Government Standard General Ledger at the transaction level. Further details surrounding these findings, together with our recommendations for corrective action, have been reported separately to CMS in our report on internal control dated November 7, 2005.

This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services (HHS), the Office of the Inspector General of HHS, the OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

A handwritten signature in black ink, reading "PricewaterhouseCoopers LLP", is located below the text. The signature is written in a cursive, flowing style.

November 7, 2005

## Report of Independent Auditors on Internal Control

To the Administrator of the Centers for Medicare and Medicaid Services and  
the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2005 and the related consolidated statements of net cost, changes in net position and financing, and the combined statement of budgetary resources for the year then ended and have issued a report thereon dated November 7, 2005. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*.

We did not audit the financial statements of the Health Programs which are a major subset of the CMS administered programs, which statements reflect total combined assets of \$28,508 million and total combined net costs of \$187,689 million, as of and for the year ended September 30, 2005. Those statements were audited by other auditors whose report thereon has been furnished to us, and our report on CMS's internal control herein, insofar as it relates to the Health Programs, is based solely on the report of the other auditors.

In planning and performing our audit, we considered CMS's internal control over financial reporting by obtaining an understanding of CMS's internal control, determined whether internal controls had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the consolidated and combined financial statements and not to provide an opinion on the internal controls. We limited our control testing to those controls necessary to achieve the following OMB control objectives that provide reasonable, but not absolute assurance, that: (1) transactions are properly recorded, processed, and summarized to permit the preparation of the consolidated and combined financial statements and Required Supplementary Stewardship Information (RSSI) in accordance with accounting principles generally accepted in the United States of America, and to safeguard assets against loss from unauthorized acquisition, use, or disposition; (2) transactions are executed in compliance with laws governing the use of budget authority, other laws and regulations that could have a direct and material effect on the consolidated financial statements or RSSI and any other laws, regulations, and government-

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wide policies identified in Appendix C of OMB Bulletin No. 01-02; and (3) transactions and other data that support reported performance measures are properly recorded, processed, and summarized to permit the preparation of performance information in accordance with criteria stated by management. We did not test all internal controls relevant to the operating objectives broadly defined by the Federal Managers' Financial Integrity Act of 1982. Our purpose was not to provide an opinion on CMS's internal control. Accordingly, we do not express an opinion on internal control.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses. Under standards issued by the American Institute of Certified Public Accountants (AICPA) and OMB, reportable conditions are matters coming to our attention, that in our judgment, should be communicated because they represent significant deficiencies in the design or operation of the internal control that could adversely affect the agency's ability to meet the internal control objectives related to the reliability of financial reporting, compliance with laws and regulations, and the reliability of performance reporting previously noted. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that errors, fraud or noncompliance in amounts that would be material in relation to the consolidated and combined financial statements or RSSI being audited, or material to a performance measure or aggregation of related performance measures, may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted certain matters, discussed below, involving the internal control and its operation that we consider to be reportable conditions (of which one is considered to be material weaknesses).

### **Medicare Program**

Over the past year, CMS has made progress in addressing the financial systems, analyses and oversight weaknesses noted during fiscal year 2004:

- CMS established a Risk Management and Financial Oversight Committee which ensures that there is cross-functional involvement in the monitoring of business activities to identify situations where accounting evaluation or decision-making may be necessary.
- CMS successfully transitioned four Medicare contractor sites to HIGLAS, the Agency's fully integrated general ledger system. HIGLAS is now the system of record for these contractor sites.
- CMS enhanced its policies and procedures by developing a formal written process to evaluate and approve changes in accounting and financial reporting policies.

## Report of Independent Auditors on Internal Control

- CMS improved procedures for handling correspondence that relates to complaints and allegations about CMS employees or other matters causing legal, operational, or financial risk to CMS.
- CMS released an updated version of the Health Plan Management System (HPMS) Monitoring Module, which contains functionalities to accommodate the reporting of Targeted Appeals Monitoring Strategy (TAMS) outcomes in monitoring visits and provided a new HPMS Monitoring Module Users Guide.
- CMS performed Continuous Quality Improvement (CQI) assessments in order to determine whether the managed care audits were timely, completed accurately and in accordance with established procedures and guidelines. The CQI assessments provided the impetus for the development of additional training, updated monitoring guides and additional standard policies and procedures.
- CMS has initiated a comprehensive evaluation initiative related to managed care oversight (1) assessing whether standard operating procedures exist for all application and audit activities; (2) determining if components responsible for reviewing applications and conducting managed care audits are adhering to these SOPs; (3) reviewing applications and performing assessments to determine if documentation exists to support decisions articulated in the audit and application files; and (4) working with operations staff to correct identified deficiencies before the beginning of the 2006 CFO Act audit.

While progress has been made during the current year, we continued to note control weaknesses regarding CMS's Medicare managed care benefits payment cycle, financial systems, and Medicare electronic data processing.

## Material Weakness

### Managed Care Benefits Payment Cycle

CMS lacks a comprehensive control environment related to the managed care benefits payment cycle and the oversight of managed care contractors which include Medicare Advantage Organizations (MAO) and Demonstration projects. The existence of a payment process outside of the Office of Financial Management and lack of integration of accounting processes within operating procedures related to managed care organizations establishes an environment where the risk of inaccurate payments is not sufficiently mitigated.

#### *Overview*

The CMS Medicare benefits expense is composed of two major components, fee-for-service and managed care. Fee-for-service expenditures are processed and paid for by Medicare Contractors, while managed care expenditures are processed and paid by central office. In January of 2005, CMS completed a system conversion to the Medicare Managed Care System (MMCS) for payments to the managed care organizations which resulted in payment adjustments of \$1.3 billion in the second quarter, \$507 million in the third quarter, and \$1.3 billion in the fourth quarter, compared to the adjustments in the first quarter in the previous system which totaled \$469 million.

While the majority of these payment errors have been identified and corrected or accrued for at the managed care plan level as of November 7, 2005, existing CMS policies and procedures are not sufficient to adequately reduce the risk of material benefit payment errors from occurring or not being detected and corrected in a timely manner in the managed care benefits payment cycle.

#### *Inadequate Procedures to Review and Process Managed Care Payments*

Managed care organizations are paid using two methodologies: (1) a risk-based methodology in which multiple demographic and health factors are used to determine the reimbursement rate for a beneficiary and (2) a cost-based methodology in which a plan is reimbursed a predetermined amount per beneficiary which is then adjusted to actual cost incurred during the year through the cost settlement process.

- PwC noted instances of inadequate policies, documentation and supervisory review related to the authorization and payment process for risk-based payments as evidenced by the following:

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- CMS has not established procedures to reconcile beneficiary level payments that are calculated and authorized to the actual payment request sent to Treasury. PwC attempted to reconcile the total amount calculated by the MMCS system to the amount authorized for payment by DEPO on a monthly basis and noted unreconciled differences ranging from \$1.7 million to \$66 million.
  - CMS did not maintain readily accessible and up-to-date logs of anomalies or errors resulting from their review of plan level payments.
  - The current methodology employed to analyze payment information is based on a simple fluctuation analysis on month to month payments. This simplistic model has identified some errors but fails to consider additional variables which may indicate potential payment issues (e.g. change in the number of enrollees).
  - CMS was unable to provide accurate beneficiary level payment information in a timely manner. PwC noted inaccuracies between the production files used to calculate the benefit payments and the amounts authorized for payment. These inaccuracies were caused by the maintenance of multiple production files and not properly identifying the beneficiary files used in the production of payment files.
  - Adjustments were made to plan payments processed in MMCS based on prior months actual payments from the predecessor system without considering other factors that may have caused changes. The adjustments ranged from a reduction of \$630 thousand to an increase of \$7.5 million for the individual plans.
- CMS failed to provide documentation to support the settlement of cost reimbursed managed care organizations, as well as, documentation to support the recording of payables and receivables for cost settlements. Cost based reimbursement represents approximately \$1.6 billion in annual benefits expense. PwC sampled forty-five plan settlements of which CMS failed to provide any documentation for sixteen (36%) of the settlements. For the remaining twenty-nine plans in the sample, PwC tested a total of 1,305 attributes in which the documentation for a total of seventy-four of the attributes did not meet CMS's requirements. These seventy-four exceptions were noted in twenty five of the twenty-nine files received.

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- For risk based plans, CMS processed manual adjustments for managed care payments without calculating or adjusting the amount at the beneficiary level which is the basis of the transaction (for example, in April 2005 CMS processed \$13 million in manual adjustments). This methodology may lead to inaccurate payments.
- CMS was unable to provide policies and procedures related to the validation of the demonstration project payments and settlements.
- CMS has not established proper segregation of duties related to managed care payments. One division has the authority to manually adjust plan payments calculated by the MMCS system and is responsible for validating and authorizing the payments. This process is limited to a small group of people whose work is not subject to independent review.

***Lack of Documentation and Procedures to Determine Eligibility of Organizations***

- CMS was unable to provide comprehensive documentation of organizations that were approved during the fiscal year as either new managed care providers or for the expansion of their service areas. PwC noted exceptions in nineteen (42%) of the forty-five contracts reviewed, where documentation did not meet CMS requirements.. Examples of the missing documentation included: audited financial statements, marketing materials, reviewer signoff, and state licensures.
- CMS does not have comprehensive policies and procedures for the review of new applications as evidenced by their inability to provide procedures related to new applications for special needs plans.
- CMS was unable to provide policies and procedures to document the acceptance and approval of demonstration projects.

***Lack of Comprehensive Methodology in Implementation of New Payment System***

- CMS implemented the MMCS system despite known deficiencies in the system which resulted in erroneous payments. The inability of CMS to correct these errors during the year resulted in an accrued payable of \$500 million in the September 30<sup>th</sup> financial statements. Inaccurate payments were made throughout the year due to the use of inaccurate information such as:
  - Improper risk factors were applied.

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- Erroneous demographic factors were applied.
  - Incorrect End Stage Renal Disease payment balances were used.
  - Inaccurate frailty risk factors for institutional beneficiaries were used.
- CMS failed to establish a systematic method for identifying, documenting and correcting errors found in the MMCS system as demonstrated by the following:
    - CMS was unable to provide in a timely manner a listing of system changes and their payment impact.
    - CMS did not establish expectations, related to beneficiary population or payment dollar impact, prior to implementation of system changes to enable the agency to validate the reasonableness of the payment changes.
    - CMS was unable to categorize managed care plan or beneficiary level adjustments that occurred on a monthly basis related to system changes versus normal payment activity.
    - CMS did not establish a comprehensive testing methodology to review the monthly payments made to managed care organizations. CMS relied on the managed care organizations to inform them of issues and the ad hoc review of system reports by CMS personnel.
    - CMS was unable to quantify the total amount of erroneous payments and corrections made during the fiscal year.
    - CMS was unable to explain unusual anomalies in corrected payment adjustments to managed care plans. For example, for a particular group of managed care plans, an additional payment of \$250 per Medicare beneficiary member was paid to correct an earlier underpayment. However, the additional \$250 was processed for only approximately 87,000 beneficiaries from a total population of approximately 180,000 beneficiaries. CMS was not able to provide documentation to adequately explain the logic error that caused this underpayment affecting only a portion of a homogeneous beneficiary population.

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- CMS failed to establish a process to ensure that accounting as well as operational issues were addressed throughout the new payment system implementation process. Throughout the testing phase of the audit, we noted significant uncertainty regarding the coordination of responsibilities among Centers for Beneficiary Choices, Office of Information Systems, Office of Financial Management and other functional and program personnel related to information systems and payments in the managed care benefits payment cycle.

*Inadequate Oversight of Managed Care Contractors*

- The Health Plan Monitoring System (HPMS) used by central office to monitor the execution and status of managed care organization oversight contains inaccurate information. This system is the core of CMS monitoring process for MAOs. Inaccurate information within HPMS weakens the monitoring of MAOs and may cause CMS to pay plans that are ineligible. The following inaccuracies were noted during the audit:
  - The HPMS monitoring review module does not contain all of the managed care organizations receiving payment from CMS. Thirteen percent of the managed care organizations included in our sample selected for testing were not included in HPMS. Incomplete information in the system may result in missed reviews and the payment of ineligible plans.
  - The HPMS monitoring review module contains inaccurate "organization type" information which is the basis for the timing and extent of oversight to be performed at the MAO. Incorrect review timing or type of review may result in the payment of ineligible plans.
  - The HPMS monitoring review module was not updated in accordance with CMS policy for the results of audits conducted during the fiscal year. The lack of timely information for management to rely upon in making determinations related to an organization's ability to meet contractual requirements may result in ineligible plans receiving payment.
- As discussed last year, CMS was unable to provide sufficient documentation to support the on-going monitoring of managed care organizations by the regional offices in accordance with CMS's policies and procedures. During the FY2005 audit, we continued to identify inconsistencies in the documentation that was available for review. The documentation maintained by the regional offices to support the execution of monitoring reviews performed at managed care organizations is inconsistent and in some instances incomplete due to the lack of established documentation policies for regional office reviews.

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- CMS lacks comprehensive policies and procedures for monitoring reviews related to demonstration projects. These are specialized health care programs/services established to address the needs of specific beneficiary populations.

**Recommendation**

We recommend that CMS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of Medicare managed care activity. Specifically, CMS should:

- Ensure that the information systems are updated on a timely basis to provide information allowing for adequate management oversight.
- Ensure that established policies address standard documentation and retention requirements for regional office monitoring reviews of the managed care organizations.
- Establish policies for regional office monitoring of demonstration projects that include tailored procedures to address the unique requirements or risks of each demonstration project.
- Perform extensive beneficiary data and payment information analysis to identify potential errors, unusual variances or inappropriate payment trends. This analysis should evaluate information such as: (1) demographic makeup of the plan's population as compared to the coverage area's population and (2) enrollment fluctuations as compared to other plans and enrollment in the overall Medicare managed care program.
- Due to the importance of the payment function in ensuring the validity and accuracy of payments to the managed care organizations and to maximize the detection of payment errors, we recommend that DEPO perform a timely reconciliation of authorized payments made by Treasury. CMS should also establish a log to document anomalies and errors that are identified and resolved as part of the authorization process in order to further support decisions made as part of the authorization process.
- With the implementation of the new system to replace MMCS for the payment of MAOs and to pay expenses related to the new prescription drug plan, CMS should establish a multi-functional process integrating personnel and systems in the managed care program, finance and information system areas with clear lines of responsibility to ensure issues are addressed in a timely manner

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- CMS should enhance their testing and documentation methodology related to the implementation of MAO payment systems. This methodology should include:
  - Parallel processing documenting differences between systems. Parallel processing should be completed for more than one payment cycle.
  - Development of a statistically-valid sampling methodology for the purpose of payment validation at the beneficiary level.
  - Process to establish expected impact of system changes prior to implementation.
  - Process to maintain an audit trail which identifies system changes and their impact at a beneficiary level.
  - Process to perform reconciliations of beneficiary level data to plan payments including plan level adjustments.
- CMS has established strong controls for monitoring fee-for service contractors in many areas listed in this material weakness and should consider implementing many of those requirements for the MAO program. In particular, implementing the data analysis methodologies employed by Medicare Contractors and Program Safeguard Contractors should provide CBC with a foundation for improving internal control within the managed care benefits payment cycle.

**Reportable Conditions – Medicare**

**Reportable Condition -- Lack of Integrated Financial System**

***Overview***

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. CMS relies on decentralized processes and complex systems—many within the Medicare Contractor organizations and CMS regional offices—to accumulate data for financial reporting. An integrated financial system, sufficient number of properly trained personnel and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

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CMS's financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair CMS's ability to efficiently and effectively support and analyze accounts financial reports.

For example, Medicare contractors currently rely on a combination of claims processing systems, personal computer based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to CMS on the 750 – Statement of Financial Position Reports and the 751 – Status of Accounts Receivable Reports. These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because CMS, and the CMS contractors, do not have a JFMIP compliant financial management system, the preparation of the 750 and 751 reports, and the review and monitoring of individual accounts receivable, are dependent on labor intensive manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS. Likewise the reporting mechanism used by the CMS contractors to reconcile and report funds expended, the 1522 – Monthly Contractor Financial Report, is heavily dependent on inefficient, labor intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS.

The lack of integration in financial reporting is clearly demonstrated through the results of the SAS 70 reviews performed at Medicare Contractors during the current fiscal year. These reports noted a total of 35 auditor qualifications related to the control objectives regarding financial reports at nine of the fourteen contractors where reviews were completed. This indicates a potential problem in relying upon the data as reported without completion of significant review by the regional and central office. This prevents the timely use and reliance of this information by both operations and financial reporting personnel. For example, the contractors are unable to report all information required for the completion of quarterly financial statements in accordance with OMB timelines and provides only minimal information at year end which supports the completion of financial statements but does provide enough data for oversight and management of the contractors' activities.

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**Recommendation**

Continue to establish an integrated financial management system for use by Medicare contractors and CMS to promote consistency and reliability in recording and reporting financial information.

**Reportable Condition -- Medicare Electronic Data Processing Access Controls and Application Software Development and Change Control**

*Overview*

The CMS relies on extensive information systems operations at its central office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts.

Our internal control testing covered both general and application controls. General controls involve organizational security plans, referred to as entity wide security plans (EWSP), access controls (physical and logical), application software development and program change controls, segregation of duties, operating systems software for servers and mainframe platforms, and service continuity plans and testing. General controls provide the foundation to ensure the integrity of application systems, and combined with application level controls, are essential to ensure proper processing of transactions and integrity of stored data. Application controls include controls over input, processing of data, and output of data from CMS application systems.

Our audit included general controls reviews at 13 sites: the CMS central office and 12 Medicare contractors. We also reviewed application controls at the CMS central office and at Medicare contractors for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems' (VIPS) Medicare System (VMS), and the Multi-Carrier System (MCS). Our audit also relied on the work and findings of the Statement on Auditing Standards (SAS 70) examinations for the 12 Medicare contractors audited.

Further, we conducted vulnerability reviews of network controls at all 13 sites audited. The vulnerability reviews included both external and internal penetration testing and network vulnerability assessments at all 13 sites, including reviews of security configurations of network servers.

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Our audit noted improvements in the following areas during the FY 2005 audit:

- Entity wide Security Program (EWSP) - These programs provide the foundation for the security culture and awareness of the organization. A sound EWSP is the cornerstone to ensure effective security controls throughout the organization. Our audit noted improvements in the entity wide security programs reviewed during the FY 2005 audit when compared to the FY 2004 programs reviews. We noted improvements regarding assessment of risks, identification of controls to reduce risk, overall security policies and procedures, completeness of EWSP plans, and training of security personnel.
- Systems Software – Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. Our audit noted considerable improvement regarding mainframe security software and operating system settings when compared to the FY 2004 audit. Our audit noted that mainframe security settings were generally in compliance with policies, monitoring controls for mainframe activities had been enhanced, and documentation over mainframe operating components, such as exits and supervisor calls, had been enhanced at most of the contractor sites audited. Our audit also noted the creation and implementation of distributed platform security configuration templates and standards at practically all sites audited. Additionally, although some failure to comply with the templates and standards were noted at contractors, the number of settings and the severity of the weaknesses noted were, in general, significantly reduced when compared to the FY 2004 audit.
- Service Continuity Planning and Testing – Service continuity relates to the readiness of a site in the case of a system outage or event that disrupts normal processing of operations. Without approved, documented, and tested business and system continuity plans, there is no assurance that normal operations may be recovered efficiently and timely. The FY 2005 audit noted significant improvement in the continuity plans and testing of the plans when compared to the FY 2004 audit. The FY 2005 audit noted that plans existed for all contractor and CMS headquarter sites audited and that practically all of the plans had been tested and in most cases used to update the prior plan.

During FY 2005, CMS made significant progress by continuing their reviews of contractors, including penetration tests and reviews of configuration settings on servers. Further, during FY 2005, CMS undertook a campaign to review, analyze and thoroughly discuss the proposed corrective action plans of contractors and those of CMS headquarters. This process included

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extensive discussions both on-site at CMS headquarters, with contractor management in attendance, and remotely with contractor management. The result of the efforts and hours dedicated to this project are clearly evident in the improvement noted in the areas of EWSP, Systems Software and Service Continuity and are, in our opinion, the reason for the reduction in risk over IT weaknesses that has resulted in two reportable conditions versus the previously noted material weakness.

During FY 2005, to address the weaknesses noted regarding the control of front end system edits for FISS, MCS and VMS, CMS management issued a new change request (CR) 3862 which provides guidance on the control of edits for the FISS, MCS and VMS systems. Further, CMS launched a project to determine contractor readiness regarding compliance with CR 3862, Initial results of the testing clearly indicate improved policies and procedures for the control of front end edits for these three systems and enhancements within all three systems which allow automated logging and tracking of edit changes for review, analysis and follow-up.

During FY 2004 CMS launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medical Modernization Act for Medicare. This evaluation program includes all eight key areas of FISMA: periodic risk assessments, policies and procedures to reduce risk, systems security plans, security awareness training, periodic testing and evaluation of the effectiveness of IT security policies and procedures, remedial activities, processes and reporting for deficiencies, incident detection, reporting and response, and continuity of operations for IT systems. This program was continued for FY 2005 and we believe that the evaluations obtained as a result of this effort have served and continue to serve CMS greatly in better understanding the current state of security operations at all Medicare contractors; not just those contractors testing during the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the reportable conditions noted, CMS continues its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, CMS continues to request and receive system security plans and risk assessments from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments for all contractors.

Efforts to address the findings noted in our review have been and continue to be challenged by budgetary constraints and the decentralized nature of Medicare operations and the complexity of fee-for-service processing. According to CMS officials, the CMS modernization program represents a long-term solution to simplify the application software code and change controls needed for more robust security. CMS is also in the process of its contractor reform initiative,

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including data center consolidation, which should reduce the number of contractors and data centers.

**Inadequate Logical Access Controls**

Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Our audit noted numerous findings regarding logical access during our controls testing. We noted that numerous security weaknesses existed that would allow internal users to access and update sensitive systems, programs and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential existed.

We consistently noted employees who did not require direct access to data and application software programs to perform their job responsibilities, but who nevertheless had been granted inappropriate update access to Medicare data and application software programs. We also noted that many contractors and, in one instance, CMS central office had not performed procedures to recertify access granted to employees on an annual basis as required by CMS standards.

As a result, we noted inconsistencies regarding access assignments, removal of access for terminated or transferred employees and the enforcement of policies and procedures regarding the administration of access approval and maintenance at the contractor sites.

**Inadequate Application Security, Development and Program Change Control**

Application security, development and program change controls provide assurance that programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security and maintenance and that only authorized and properly tested programs are implemented for production use. Our audit noted again that contractor processing sites have the ability to turn on and off front end edits in the FISS, MCS and VMS systems without consistent procedures to ensure that edits are only turned off when required, that changes to edits are properly approved prior to the change and that a complete analysis of the effect of the change to an edit and has been conducted and used to assess the overall effect on Medicare processing.

Changes to edits represent a very important area of concern because the ability to negate system edits degrades the ability to ensure that only proper data is introduced into these systems and ultimately, the Common Working File (CWF) and the National Claims History (NCH) System and other databases used to analyze claims and make decisions.

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We also noted again, although at fewer contractor sites, that application changes are being implemented without documented testing and approval and that application change control procedures were not followed at several contractor sites.

Finally, we noted again, numerous contractor sites at which application programmers had the ability to directly update production source code for applications thereby allowing them to bypass application change controls.

**Recommendations**

We recommend that the CMS continue to strengthen controls over Medicare electronic data processing. Specifically, CMS management should:

- Target contractor access control policies and procedures to ensure their sufficiency and enforcement, including recertification of access annually and assurance of proper segregation of duties for application and systems programmers.
- Provide more specific guidance to the contractors regarding procedures to formally assess and reduce risk on an ongoing basis by specifically identifying and matching controls to mitigate risks noted in their systems security plans and by specifically requiring ongoing and consistent tests of mitigating controls to ensure their continued effectiveness.
- Continue the process to assess the enforcement of CR 3862, especially with regard to the approval of changes to shared system coded edits and the use of the newly developed audit trails in the FISS, MCS and VMS systems to analyze the effect of edit modifications on Medicare claims processing and approval. The analysis of edit modifications from the system audit trails should be used to match the results to error trends resulting from contractor claims processed during periods when edits are turned off and include specific matching of error types to contractors from which the errors emanated.
- Continue and enhance processes to continuously monitor and track compliance with the security configuration models for all platforms maintained within, the CMS contractor sites, the maintainer sites and the CMS central office. CMS should greatly encourage the use of automated tools to monitor, detect and report to the CMS Information Security Office, all noncompliance with contractor, maintainer or CMS headquarter platform security configuration standards for distributed servers including WINDOWS, UNIX, router, switches, Web server and Oracle database servers on a quarterly basis

## **Reportable Condition – Health Programs**

### **Financial Management Systems and Oversight**

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. CMS relies on decentralized processes and complex systems—many within the states and regional offices—to accumulate data for financial reporting. An integrated financial system, sufficient number of properly trained personnel, and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

### **Financial Management Systems Lack FFMIA Compliance**

CMS's financial management systems, including its general ledger, grant award and expenditure systems are not fully compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the former Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The Medicaid Budget and Expenditure System (MBES) lacks sufficient integration with the CMS general ledger system as required by FFMIA. The lack of an integrated financial management system impairs CMS's abilities to adequately analyze and monitor its financial balances reported.

In addition, we noted the following systems related issues:

- During our review, testing and discussions with application MBES management, we noted that there are inadequate formal written policies and procedures in place that require periodic review of MBES/CBES(CHIP Budget and Expenditure System) user access rights, encompassing the review of access levels for employees who may have transferred within CMS/the state or for employees who may have changes in duty during the review period. Additionally, even though on June 1, 2005 CMS implemented policies and procedures relating to passwords and requirements for user email addresses in an effort to address MBES/CBES user access termination controls, we noted that the

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population of current MBES users included those who had not changed their password in over 365 days.

- Certain weaknesses were identified during our vulnerability and penetration testing. Management indicated that upgrades to the MBES servers to Windows 2003 OS would correct certain weaknesses identified.
- CMS lacks sufficient integration or reconciliation and tracking processes to ensure that obligation activity within the Payment Management System, which tracks draws for state grants, are consistent with obligation activity within CMS' general ledger. Currently, the states use a CMS 64 to report accrued expenditures to CMS while the states submit a PMS 272 to report expenditures on a cash basis to the Payment Management System resulting in inconsistent expenditure activity within the two systems for the same grant. Although CMS personnel close out grants on the General Ledger once obligations and expenditures match, old obligations are not always de-obligated within the Payment Management System leaving unexpended balances available for draws by the states. The difference between net obligations over two years old within the two systems was over \$1 billion at September 30, 2005.

CMS is currently in the process of implementing a new integrated financial management system and updating its policies and procedures that may resolve CMS' issues related to compliance with the FFMIA.

**Regional Office Oversight**

Since the late 1990's, the Health Programs' Regional Office oversight has been identified as a weakness within CMS. The Regional Office oversight of the states is a key detect control in identifying errors within State submitted financial information related to Medicaid, SCHIP and other health programs. The CMS 64, Quarterly Medicaid Statement of Expenditures, is a key submission which reported the approximately \$245 billion in fiscal year 2005 in state expenditures to CMS which flows directly to the financial statements.

In September 2000, CMSO issued financial review guides to assist the Regional Office (RO) analysts in examining budget and expenditure reports as well as to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process but their use and documentation are currently not required, but highly recommended. According to the directions provided to the Regional Office within the Guides,

“The purpose of this financial review guide is to set forth general procedures and guidelines for a uniform, comprehensive, and well-documented quarterly review of the Form HCFA-64 (currently the CMS 64) and to provide for the consistent reporting

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on the results of these quarterly reviews through the preparation of the HCFA Regional Decision Report (RDR) and reports to the States. While this guide is intended to be comprehensive in nature, this guide is not all-inclusive and must be used in conjunction with all applicable Federal laws, regulations, and policy guidance.

Additionally, certain review procedures may be expanded or curtailed depending on the complexity of a State's program and issues identified during the review process. In other instances, the time available to perform the review, staffing limitations, availability of travel funds, or management decisions may dictate adjusting and/or limiting the scope of the review. The reviewer should use professional judgment, in conjunction with management direction, in determining the scope of the review and the extent to which it should be expanded or curtailed. The decision to expand or curtail the scope of the review or review procedures must be documented by the reviewer."

These guides also set forth guidance on work paper standards and supervisory review. For example, the Guides directs the Regional Offices as follows"

"Review work shall be properly supervised. There is a professional responsibility on the part of the supervisor in charge and/or reviewer in charge to ensure that each reviewer's work measures up to the appropriate standards of professional competency and is carried out in accordance with the procedures specified in this guide. How this is accomplished depends upon the organizational structure in each RO and the specific functional responsibilities assumed by the various management and review staff in the RO. The supervisor in charge and/or reviewer in charge must exercise due care in the supervision of reviewers, the careful review of their work, and in the professional judgments made by them.

The review work shall include the examination and development of sufficient competent evidential matter to afford a reasonable basis for the RDR. How much evidence is sufficient, and what evidence is competent, standing alone or in combination with other evidence, are matters of professional judgment to be exercised by the reviewer and the supervisor in charge and/or reviewer in charge.

Time should not be spent examining or developing evidence beyond that which is needed to afford a sound basis for a professional decision on the Form HCFA-64. The elements of materiality and relative risk must be considered in performing the review. The reviewer's principal efforts should be in those areas where material problems may exist rather than in those areas which are relatively immaterial to the overall decision on the Form HCFA-64. Prescriptive review procedures should not substitute for the professional judgment of the reviewer as to what is necessary to complete the review and render a decision on the Form HCFA-64 (CMS 64)."

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The monitoring activities executed by CMS constitute critical oversight activities in light of the 11 states that, we have been informed, recently received disclaimers or qualified reports by independent auditors on compliance with Medicaid program requirements, compliance findings in single auditors' reports requiring resolution, and various differences in processes, systems, and issues from state to state. We noted the following during our review:

- *Documentation and Scope of Reviews* - Within the CMS Regional Offices analysts are not required to follow the CMS Financial Review Guide to assess each state's budget requests, quarterly expenditure reports, and other state activities related to SCHIP and Medicaid funding. We noted in the two regions visited that the Regional Office did not consistently use the review guide (for quarterly and budgetary reviews) and, when the guide was used (for CMS-64s), the reasons steps were not performed were not always documented. Additionally, we noted that documentation for certain line items on the CMS-64 supporting the analysts' review was lacking. The line items affected included those relating to adjustments and other expenditures for varying amounts. Finally, practically none of the documents examined in our sample had evidence (e.g. sign-off) that a supervisory review was performed. Additional details are as follows:
  - In one Regional Office, a review guide for the CMS-64 was completed for all six states; however, for four of the six states, the review guides had steps that were marked "not performed" or "N/A" without explanations as to why the step was not performed or not applicable. Review guides for the CMS-21 (Quarterly State Children's Health Insurance Program (SCHIP) Statement of Expenditures for Title XXI), CMS-21B (Quarterly SCHIP Budget Report for the Title XXI Program), and CMS-37 (Quarterly Medicaid Program Budget Report) were not completed for any of the six states. As discussed above, although the reviewer may curtail the scope of his review, an explanation should be documented as to the reduction of scope.
  - In another Regional Office, a review guide for the CMS-64 was not completed for one of the four states. A review guide for the CMS-37 was not completed for three of the four states. A review guide for the CMS-21 was not completed for two of the four states. A review guide for the CMS-21B was not completed for all four states.
  - In connection with our CMS-64 review we looked for completed review guides, variance analyses, and supporting documentation for individual line items. For 2 states we noted missing documentation, and we noted differences between the line item amounts and the supporting documentation for another state. For the CMS-21, CMS-21B, and CMS-37, we reviewed the completed review guides and trend analyses; however, we did not test for supporting documentation for line items.

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- *Monitoring of state submissions* - Analysis of changes in quarterly budget and expenditure submissions is a major consideration in the Regional Office's recommendation to award a grant or validate expenditures and a step in the CMS Financial Review Guide. During our visit to the Regional Offices, we noted that analysts did not adequately perform trend analyses on Medical Assistance Payments (MAP), Administration (ADM), and SCHIP payments. For certain states, although evidence of trend analysis was available, the scope of the items selected for review was not documented in the workpapers nor was there evidence of which amounts were investigated. In many cases, explanations for variances were not sufficiently documented to assist a reviewer in verifying that CMS gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.
  - At one Regional Office, we noted the following:
    - For the CMS-64, trend analyses were prepared for all six states; however, three of the six states analyses had no scope/threshold identified and explanations for variances.
    - For the CMS-37, CMS prepared a trend analysis for five of the six states; however, one did not have a scope/threshold identified nor did it have explanations for any variances.
    - For the CMS 21, CMS prepared a trend analysis for one of the six states; however, it did not have a scope/threshold identified nor did it have explanations for any variances.
    - For the CMS-21B, CMS did not prepare trend analysis for six of the six states.
  - At another Regional Office, we noted the following:
    - For the CMS-64, trend analyses were prepared for all four states; however, three of the four states' analyses had no scope/threshold identified and no explanations for variances.
    - For the CMS-37, for three of the four states CMS did not prepare a trend analyses, and the one trend analyses prepared did not have a scope/threshold identified nor did it have explanations for any variances.

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- For the CMS-21, two of the four states CMS did not prepare the analysis. For the two analyses prepared, no scope/thresholds were identified and no explanations for variances were documented.
- For the CMS-21B, CMS did not prepare the analysis for four of the four states.

In FY 2005, CMS took steps to increase regional office personnel by hiring more than 100 analysts to work in the states to ensure compliance with Medicaid requirements. These analysts, who have undergone extensive training to ensure adequate knowledge of CMS policies and procedures, began their oversight activities in FY 2005. Our review in FY 2005 noted certain improvements in state oversight as compared to weaknesses identified during FY 2004; however, continued emphasis on the extent of reviews and documentation of procedures performed is still needed. It should be noted that our review encompassed the first two quarters of FY 2005. Management has stated that certain corrective actions implemented by CMS were not fully implemented at the time of our review.

The GAO's *Standards for Internal Control in the Federal Government* indicates that internal control monitoring should assess the quality of performance over time and ensure that findings of audits and other reviews are promptly resolved. Without the required use of the guide providing minimum policies, appropriate monitoring and oversight of state operations, deficiencies in internal control may allow significant misstatements to occur without being identified in a timely manner.

**Medicaid and SCHIP Entitlement Benefits Due and Payable**

Medicaid entitlement benefits due and payable (IBNR), totaling approximately \$20 billion at September 30, 2005, represent the cost of services incurred by states on behalf of CMS but not paid at the end of the fiscal year. CMS bases its estimate of IBNR receivables and payables on historical trends of expenditures and prior year payables identified on surveys obtained from the states. CMS validates their estimate by considering current year program changes, performing analytical procedures, and evaluating significant differences.

Although we believe the methodology currently employed by CMS can produce a reasonable IBNR estimate for Medicaid, the process is highly dependent on information provided by the various states. Errors, inconsistencies and varying interpretations at the state level can occur and significantly affect the CMS IBNR liability. It should be noted that a 15 month time-lag exists from the date of the state IBNR information (typically June 30, 2004) to the date of CMS' fiscal year end calculation (September 30, 2005). Examples of factors that could affect the IBNR follow:

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- Health care cost trend rates, timing of payments by states, state system changes, enrollment growth, federal share percentage changes, plan changes, cost cutting measures, and other factors can have a significant effect on CMS' IBNR. CMS does not have a systematic process to routinely capture such factors in the IBNR calculation.
- Also, because of the 15-month time lag between the state IBNR information and CMS's fiscal year end calculation, changes can occur at a state level and not be taken into consideration for the IBNR calculation. In order to gain a better understanding, in coordination with Ernst & Young, CMS sends each regional office a questionnaire regarding states Medicaid activity. The purpose of this questionnaire is to obtain qualitative information on IBNR trends. Almost all of the regions did not have a good understanding of IBNR trends for certain states. Regions did not obtain completed questionnaires for 9 states [approximately \$2 billion of IBNR] as of the date the financial statements were drafted.
- Three states did not submit IBNR survey information and had to be extrapolated using trending analyses, and three other states re-submitted last year's information.

Although the total draws and expenditures, used in the overall Medicaid IBNR calculation, were reasonable, we noted various clerical errors in the spreadsheets that were used to calculate IBNR and for trending and analyses purposes. For example:

- Cash draws to pay Medicaid claims for 7 states were misclassified and reflected as corresponding to other states' activity. While this error did not adversely impact the overall Medicaid IBNR calculation, it would affect each individual state's analysis of expenditures and IBNR reasonableness.
- CMS uses a worksheet containing state draws, average daily draws, past IBNR, and IBNR average days to determine the reasonableness of the national Medicaid IBNR calculation. When reviewing this analysis, we noted that 2004 expenditures did not agree with supporting documentation by \$13 billion.

The internal control process over the Medicaid IBNR calculation did not detect the above errors in a timely manner. Although the individual state entries in the spreadsheets were primarily used for analyses purposes and the total expenditures used in the national Medicaid calculation were reasonable, these discrepancies indicate that errors may occur without being identified and corrected. Further, we noted that although certain supervisory reviews of the IBNR calculation were performed in the Office of Financial Management, additional input from Program or OACT offices was not obtained.

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These individuals have additional expertise and knowledge that may identify anomalies impacting the estimate. While we believe the amount reported is reasonable based on CMS' and our analysis, there is insufficient assurance that the current process would identify significant anomalies. Adequate analysis, follow up and review is, therefore, extremely important.

For SCHIP, CMS has not implemented procedures to accrue an estimate for SCHIP IBNR payables and receivables at year-end. However, a portion of SCHIP expenditures is reimbursed on a fee for service basis, indicating the need for an IBNR accrual.

**Medicaid Claims Estimated Improper Payments**

The Improper Payments Information Act requires agencies to review annually all programs and activities they administer and identify those which may be susceptible to significant erroneous payments. For all programs and activities identified as susceptible to significant erroneous payments, agencies are required to determine an annual estimated amount of erroneous payments made in those programs and activities. Although both Medicaid and SCHIP have been identified as programs which are susceptible to improper payments, CMS has not completed its implementation of a process to estimate improper payments.

**Recommendations**

We recommend that CMS continue to develop and refine its financial management systems and processes to improve its analysis and oversight of Medicaid activity. Specifically, we recommend that CMS:

- Continue to enhance its financial systems to ensure compliance with the FFMIA.
- Enhance its policies and procedures to ensure the following:
  - All system administrators should perform periodic reviews of access authorization for the MBES/CBES application. Evidence of this periodic review should be maintained.
  - A process should exist for communicating terminated employees to the MBES/CBES administrators and for the timely removal of those employees.
- Continue to refine its procedures to provide a mechanism for CMS Central and Regional Offices to monitor states' activities and enforce compliance with CMS financial management procedure by:

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- Providing specific guidance in the use and preparation of the Financial Review Guides to ensure that the Regional Offices consistently use the guide to document procedures performed during the quarterly expenditure and budgetary reviews and that any decision to expand or curtail the scope of the review or review procedures be documented.
- Developing a specific scope to be used to identify areas for review and that this scope, or any deviations from the scope, be documented within the trend analysis work paper(s) along with explanations.
- We recommend that CMS enlist OACT to help review the annual Medicaid IBNR calculation. OACT is skilled in performing such estimates and brings a good understanding of how health care cost trends, program changes, etc. should affect the IBNR calculation. We further recommend that formal analytical review procedures (i.e. documented and reviewed) be developed to catch clerical errors in the spread sheets and that CMS proactively obtain input from the states via the Regional Offices on trends, system changes, program changes, etc. associated with individual states. It would be beneficial to prepare a white paper every year addressing the various factors affecting IBNR and creating a link between qualitative information (e.g. trends, state system changes, OACT, regional office and CMSO input, etc.) and the quantitative calculation. CMS should also calculate IBNR based on a three year average using the current year survey (e.g., 2005, 2004 and 2003) as a reasonableness check on the IBNR calculated using state information 15 months in arrears. This procedure can help to detect/and factor in current trends affecting the IBNR calculation. Consideration should also be given to refining the average-days calculation which does not currently appear to corroborate the IBNR used in the financial statements.
- In order to help strengthen the estimating process we suggest CMS consider developing a methodology to collect the necessary data to estimate an IBNR amount from claims data maintained internally. We recognize this is a formidable task and validated claims information lags a few years, however, development of such a procedure may be helpful to CMS (particularly if OACT becomes involved in the Medicaid IBNR process) in performing an independent check (look-back) on the IBNR developed from state surveys if done several years in arrears to benchmark the existing process using actuarial concepts.
- For SCHIP, we recommend that CMS identify a methodology for estimating an IBNR for SCHIP related expenditures. We understand CMS is currently pursuing an approach similar to that used for Medicaid, and we encourage finalization of this approach.

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- We recommend required reviews of the IBNR calculation and state surveys by the Program, Financial and OACT divisions to identify any potential anomalies or changes to the Health Programs that could impact the IBNR calculation.
- We recommend CMS continue in the implementation of a process to estimate improper payments for both the Medicaid and SCHIP- related payments.

\* \* \* \* \*

**Internal Control Related to Key Performance Indicators and RSSI**

With respect to internal control relevant to data that support reported performance measures in the financial report, we obtained an understanding of the design of significant internal control relating to the existence and completeness assertions, as required by OMB Bulletin No. 01-02. Our procedures were not designed to provide assurance on the internal control over reported performance measures and, accordingly, we do not express an opinion on such control.

In addition, we considered CMS's internal control over RSSI by obtaining an understanding of CMS's internal control, determined whether these internal controls had been place in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on these controls. Accordingly, we do not provide an opinion on such controls.

We also identified other less significant matters that will be reported to CMS's management in a separate letter.

This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services, the Office of the Inspector General of the Department of Health and Human Services, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

*PriceWaterhouseCoopers LLP*

November 7, 2005



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November 7, 2005

PricewaterhouseCoopers, LLP  
1301 K Street NW  
Washington, D.C. 20005

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2005 financial statements. Your report identifies one material weakness, Managed Care Benefit Expense Cycle, and three reportable conditions, Lack of Integrated Financial Systems, Medicare Electronic Data Processing Access Controls and Application Software Development and Change Control, and Health Programs Financial Management Systems and Oversight. The CMS generally concurs with the findings and description of the material weakness and reportable conditions. As noted in your report, CMS continued to improve its financial management performance in FY 2005 in many areas. This is especially true for those areas that were formerly reported as material weaknesses and are now being reported as reportable conditions. For example, CMS is successfully addressing its' lack of an integrated general ledger accounting system through our efforts implementing the Healthcare Integrated General Ledger Accounting System (HIGLAS). HIGLAS has been implemented at four Medicare contractors and will strengthen CMS' financial management by standardizing the collection, recording, and reporting of financial information among all the Medicare contractors and CMS.

Although we are pleased with these results, we have already developed an overall plan to further strengthen our financial management processes and ensure that any areas identified as weaknesses are corrected. The CMS remains committed to the improvement of its financial operations so that it can fulfill its stewardship responsibilities and maintain the highest level of accountability for the management of the Agency's financial resources. The CMS will continue to track and report our progress on a regular basis.

I would also like to thank your office for the professional and cooperative manner in which they conducted their audit and look forward to working with our auditors in correcting these outstanding issues.

Sincerely,

Timothy B. Hill  
Chief Financial Officer



# Other Congressional Reports

## **SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT**

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The Federal Managers' Financial Integrity Act (FMFIA) requires executive agencies to report annually if: (1) they have reasonable assurance that their management controls protect their programs and resources from fraud, waste, and mismanagement, and if any material weaknesses exist in their controls, and (2) their financial management systems conform with Federal financial management systems requirements.

The CMS assesses its management controls and financial management systems through: (1) management control reviews and management self-assessments, (2) OIG audits, (3) GAO audits and high risk reports, (4) the CFO financial audit, (5) other review mechanisms, such as SAS 70 internal control audits, and (6) certification and accreditation of systems. As of September 30, 2005, the management controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved. However, one material weakness existed and a noncompliance was identified.

### **Material Weakness—Managed Care Benefits Payment Cycle**

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The internal controls over the Medicare managed care program need to be improved. Inadequate internal controls over audit and payment activities for the Medicare managed care program resulted in the following CFO-audit related findings: (1) CMS does not maintain sufficient documentation to support the on-going monitoring of managed care organizations by the regional offices in accordance with CMS policies and procedures; (2) inadequate policies, documentation, and supervisory controls exist related to the authorization and payment process for the Medicare managed care program; (3) during 2005, CMS underwent a major systems conversion and implemented the Medicare

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Managed Care System (MMCS) payment system that resulted in erroneous payments for Medicare managed care contractors. Inaccurate payments were made throughout the year due to the use of inaccurate information. The CMS failed to establish a systematic method for identifying, documenting, and correcting errors found in the MMCS system; and (4) CMS has not established proper segregation of duties related to authorization and controls around payments made to Medicare managed care contractors.

The CMS will follow up with all ROs to ensure that the ROs follow the Medicare Advantage organization, Cost organization, Demonstration, and Health Care Pre-payment Plans audit protocols and document retention standard protocols. In addition, CMS will continue to work with an external contractor to develop standard operating policies and procedures and internal controls around payment system functions. The CMS will work to develop systems for better identifying system errors and related payment errors as well as work to strengthen the segregation of duties around managed care payments.

### **Noncompliance**

The CMS financial management systems, because they are not integrated, do not conform to government-wide requirements. We have implemented a comprehensive plan to bring our financial systems into compliance. Specifically, we have initiated steps to implement an integrated general ledger system known as HIGLAS for the Medicare contractors, and CMS Central and Regional Offices. The HIGLAS will initially integrate our financial systems with the Medicare contractors' existing shared claims processing systems. In addition, the current mainframe-based financial system will also be replaced by HIGLAS, the foundation of which is a web-based, certified Joint Financial Management Improvement Program, commercial-off-the-shelf system.

## MEDICARE'S VALIDATION PROGRAM FOR JCAHO ACCREDITED HOSPITALS

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### **Introduction**

Section 1865 of the Social Security Act (the Act) provides that hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are deemed to meet the Medicare Conditions of Participation (CoPs). While JCAHO-accredited hospitals are not subject to routine Medicare surveys by the State survey agencies, subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with any such State agency to survey JCAHO-accredited hospitals on a selective sample basis, or in response to allegations of significant deficiencies which, if substantiated, would adversely affect the health and safety of patients. The Act further requires, at section 1875, the Secretary to include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the hospital validation program.

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The purpose of the hospital validation program is to determine if the JCAHO accreditation process provides a reasonable assurance that accredited hospitals are in compliance with the statutory requirements set forth at subsection 1861(e) of the Act for participation in the Medicare program as hospitals. In FY 2004, CMS randomly selected approximately 1 percent of all JCAHO-accredited hospitals to receive a validation survey.

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO standards. Following the completion of an on-site survey, the JCAHO makes an accreditation decision. In FY 2004, the accreditation decisions included: accreditation, accreditation with requirements for improvement, conditional accreditation, and accreditation denied.<sup>1</sup> Accreditation means that the hospital meets all JCAHO standards and requirements. Accreditation with requirements for improvement means that the hospital is granted accreditation with the assurance that the identified recommendations for improvement are corrected. The JCAHO requires hospitals with requirements for improvement to submit a written progress report or undergo a follow-up survey. Conditional accreditation results when a hospital is not in substantial compliance with JCAHO standards, but is believed to be capable of achieving acceptable compliance within a stipulated time period. Findings of correction, which serve as the basis for further consideration of awarding full accreditation, must be demonstrated through a short-term follow-up survey. Table 1 summarizes the JCAHO accreditation decisions for Medicare-approved hospitals receiving a triennial survey in fiscal years 2003 and 2004.

**TABLE 1**  
**JCAHO Accreditation Decisions,**  
**Medicare-Approved Hospitals Surveyed in FY 2003 and FY 2004**

<b>Accreditation Decisions</b>	<b>No. Hospitals, 2003 (Percent)</b>	<b>No. Hospitals, 2004 (Percent)</b>
Accreditation	320 (21.0)	244 (14.94)
Accreditation with Requirements for Improvement	1191 (78.15)	1364 (83.53)
Conditional Accreditation	13 (0.85)	23 (1.41)
Preliminary Denial of Accreditation	0 (0)	2 (0.12)
Accreditation Denied	0 (0)	0 (0)
Total Surveyed	1524 (100)	1633 (100)

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<sup>1</sup> JCAHO accreditation decisions also include preliminary denial of accreditation and provisional accreditation. [During FY 2003, CMS did not recognize provisional accreditation for deeming.] Effective January 2004, JCAHO redefined their accreditation decision categories and CMS now recognizes provisional accreditation for deeming. The JCAHO considers all hospitals to be 'accredited' except those that are not accredited. The CMS currently accepts the JCAHO definition for deeming purposes.

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### Sample Validation Surveys

A total of 61 sample validation surveys were performed in JCAHO-accredited hospitals during FY 2004. The validation sample includes both traditional validation surveys and mid-cycle validation surveys. The traditional validation survey is a full survey in which the hospital is evaluated for compliance with all Medicare CoPs. The traditional survey is the “look behind” method historically used by CMS for validation surveys and is conducted within 60 days following the hospital’s JCAHO accreditation survey. There were 44 traditional validation surveys conducted during FY 2004. The mid-cycle surveys in the current validation sample included only hospitals in which the JCAHO survey had identified serious deficiencies and were primarily intended to assess the JCAHO’s effectiveness in assuring that the accreditation process resulted in the correction of those deficiencies.

### Validation Survey Findings

In FY 2004, a total of 61 JCAHO-accredited hospitals received a validation survey, 44 hospitals received a traditional survey, and 17 received a mid-cycle survey. Table 2 presents the number of validation surveys, along with the compliance determinations (i.e., if the results of a validation survey showed noncompliance with one or more CoPs, the hospital was ‘out of compliance’). A hospital may have had deficiencies of a lesser severity (e.g., standard level) and still be considered in compliance.

**TABLE 2**  
**Compliance Determinations of Validation and**  
**Non-Accredited Hospital Surveys, FY 2004**

Survey Type	No. Hospitals Out of Compliance (Percent)	No. Hospitals In Compliance (Percent)	Total
Sample Validations	26 (41.3)	37 (58.7)	63
Routine Non- Accredited	47 (19.5)	194 (80.5)	241

### Allegation (Complaint) Surveys

In addition to sample validation surveys, CMS conducts substantial allegation (complaint) surveys in JCAHO-accredited hospitals. The CMS evaluates each complaint received on an accredited hospital. Based on that evaluation, if CMS believes that the hospital may have a CoP out of compliance, CMS will then authorize the State agency to conduct a substantial allegation survey.

In FY 2004, 4,293 allegation surveys of JCAHO-accredited hospitals were conducted with 139 found out of compliance with one or more CoPs. Also, 366 allegation surveys of

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non-accredited hospitals were conducted with 45 found out of compliance with one or more CoPs. With respect to complaints received that warranted an on-site investigation, 92 percent involved allegations against JCAHO-accredited hospitals. This is not surprising considering that JCAHO-accredited facilities account for approximately 90 percent of the Nation's inpatient hospital beds.

Accredited hospitals have a complaint substantiation rate of 3.24 percent, while complaints against non-accredited hospitals were substantiated 12.3 percent of the time. At present, CMS does not include allegation surveys in the disparity rate calculation, although it may develop specific measures to apply to complaint data and findings in the future. Table 3 summarizes the most frequently cited CoPs found during allegation surveys of both JCAHO-accredited and non-accredited hospitals.

**TABLE 3**  
**Most Frequently Cited Conditions of Participation**  
**During Allegation Surveys, 2004**

JCAHO-ACCREDITED HOSPITALS		NON-ACCREDITED HOSPITALS	
Condition Not Met	Frequency (Percent Substantiated)	Condition Not Met	Frequency (Percent Substantiated)
1 Patients' Rights	51 (1.2)	Nursing Services	18 (4.9)
2 Nursing Services	50 (1.2)	Patients' Rights	12 (3.3)
3 Governing Body	35 (0.8)	Quality Assessment & Performance Improvement (QAPI)	10 (2.7)

## Disparity Rate

The rate of disparity is the percentage of sample validation surveys for which a State survey agency finds noncompliance with one or more Medicare conditions and no comparable condition level deficiency was cited by the accreditation organization, where it is reasonable to conclude that the deficiencies were present at the time of the accreditation organization's most recent survey.

### **Traditional Validation Survey Disparity**

Of the 44 traditional validation surveys performed in JCAHO-accredited hospitals in FY 2004, the State survey agencies found non-compliance with one or more conditions in 17 hospitals. Comparison of the JCAHO-accreditation survey reports with the validation survey reports for these hospitals revealed that in 12 of the 17 hospitals, the accreditation survey did not identify deficiencies comparable to the condition level deficiencies cited

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by the State agency surveyors. This equals a disparity rate of 27 percent. In 58 percent of the hospitals in which JCAHO missed a deficiency finding, the sole type of deficiency is related to the Physical Environment CoP. Compliance with the Life Safety Code (LSC) is the most common issue in the Physical Environment CoP, typically involving fire safety precautions. This has been the subject of frequent communication between CMS and JCAHO, and the JCAHO has implemented various measures to improve their performance in this area. A number of these measures are highlighted later in this report.

The health and safety CoPs found out of compliance most frequently for the 44 traditional validation surveys performed in FY 2004 are shown in Table 4, with the number of times the JCAHO identified similar findings during the accreditation survey.

**TABLE 4**  
**Most Frequently Cited CoPs**  
**During Traditional Validation Surveys**

Condition of Participation	Cited by the State Agency	Similar Findings Identified by JCAHO
1 Physical Environment (Includes Life Safety Code)	15	8
2 Governing Body	5	1
3 Patients' Rights	2	0
4 Pharmaceutical Services	2	1
5 All Other CoPs	10	3
6 Total	34	13

### ***Mid-Cycle Validation Survey Findings***

The mid-cycle validation surveys are used as an assessment of the JCAHO's ability to ensure that hospitals take necessary corrective action to come into compliance with accreditation standards. Our findings indicate that the JCAHO performed exceptionally well in this aspect of the accreditation process. In all but one of the 17 mid-cycle surveys conducted in FY 2004, the problems requiring correction by the JCAHO and that would have resulted in non-compliance with the Medicare CoPs had been corrected by the hospital, and remained in compliance at the time of the State agency mid-cycle survey, generally about 18 months after the accreditation survey. In assessing the completion of required correction of deficiencies identified in the accreditation survey, JCAHO-accredited hospitals achieved a corrective action adherence rate of 94.1 percent. This finding is particularly significant in that JCAHO accreditation surveys with requirements for

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improvement increased by 5 percent in FY 2004, and represent 83.5 percent of all accreditation surveys performed during that period.

Although the JCAHO performed well in ensuring the correction of deficiencies, it should be noted that the State survey agencies identified additional CoP-level deficiencies, unrelated to the requirements for improvement cited by the JCAHO, in 6 of the 17 hospitals. It is outside the scope of the current mid-cycle sample to calculate a rate for these findings because of the time lapse between the two surveys and the sample being targeted to hospitals with JCAHO-identified deficiencies. However, we are considering expanding the use of the mid-cycle survey in the future as a way to evaluate JCAHO performance in ensuring accredited hospitals maintain continued compliance. This will require an additional sample of validation surveys beyond the resources available to the validation program at this point. The CMS is working to increase the overall sample size and identify possible alternate methods to evaluate this very important element of JCAHO performance.

Using the sample validation surveys performed in FY 2004, we were able to evaluate two important parameters of JCAHO performance: the identification of deficiencies, and the ability of the JCAHO process to ensure correction of deficiencies. While there remains a need for additional improvement in reducing the disparity in survey findings regarding the identification of deficiencies, particularly with respect to Physical Environment CoP and the application of the Life Safety Code, the findings demonstrate that JCAHO's requirements for improvement lead to improved hospital compliance. The CMS expects that if it is able to devote more resources to the validation program and increase the sample size in the future, it will be able to add additional performance metrics, for example, using additional mid-cycle surveys to evaluate JCAHO's ability to ensure continuous compliance in accredited hospitals.

### JCAHO Improvement Efforts

While the regulations at 42 CFR 488.8(d) provide for a deeming authority review when an accrediting organization's disparity rate exceeds 20 percent, current law does not provide for the removal of deeming authority from the JCAHO's hospital accreditation program. As in previous years, CMS will continue to work closely with JCAHO to minimize differences in the two organizations' standards and procedures to further reduce disparities in the future.

Significant progress has been made with respect to these efforts. The JCAHO did initiate implementation of the CMS recommendations to improve their evaluation of Life Safety Code compliance in calendar year 2004, and demonstrated some improvement during this validation review period. These initiatives included hiring and training a significant number of specialty surveyors, and were fully implemented in the field during 2005. The JCAHO has added 50 such specialist surveyors, all professional engineers whose qualifications have been evaluated by the American Society for Healthcare Engineering. The CMS expects to see a more significant reduction in disparity in this area in future years. The CMS also notes that JCHAO is making greater use of conditional accreditation and preliminary denial of accreditation (the number nearly doubled from 13 in FY 2003 to 25 in FY 2004) as a mechanism to bring hospitals into compliance.

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The JCAHO has also committed to activities to identify and reduce any “gaps” between the hospital accreditation program and the Medicare survey and certification program. In an effort to promote consistency and further reduce disparate results in the survey processes, a joint workgroup of CMS and JCAHO staff has begun to analyze the JCAHO’s accreditation standards, elements of performance, and evidence of compliance and compare their intent and outcomes to the Medicare CoPs, interpretive guidelines, and survey procedures. In addition, the JCAHO will begin performing “look behind” surveys after the accreditation survey in a number of hospitals, with the specific objective of evaluating hospital compliance against the specific functions and requirements as outlined in the Medicare CoPs. Efforts are also continuing to enhance and improve the exchange of information between CMS and JCAHO. These efforts had slowed somewhat due to information management resource constraints at JCAHO, but work has recently accelerated and CMS is making purposeful progress in this area.

It should be noted that as of January 1, 2006, both JCAHO and CMS will have implemented a 100 percent unannounced policy with respect to hospital accreditation and certification surveys. The CMS believes that this important change should contribute to both increased compliance and increased correlation of survey findings.

### CMS Oversight Improvement

In July 2004, the Government Accountability Office (GAO) issued a report on CMS oversight of the hospital accreditation program.<sup>2</sup> In that report, the GAO made several recommendations that might be used to improve CMS oversight of the hospital accreditation program, including modifying the method used to calculate the disparity rate, identifying additional indicators of JCAHO performance, and increasing the validation sample size. In response to that report, and the results from CMS’ internal analysis of the hospital validation program and CMS oversight of the JCAHO accreditation process, CMS has undertaken further action to enhance its oversight of JCAHO activities in the hospital accreditation process. A number of those actions are described below:

**Regulatory Actions to Improve Oversight.** The CMS is developing proposed approaches to revise the regulations to refine and improve the current method of measuring and calculating any differences between JCAHO findings and CMS-sponsored validation surveys and explore additional and alternative performance measurement methods. Possible regulatory revisions will also explore different methods that may be used by CMS to gain additional and more substantial information on the JCAHO processes. Additionally, we will explore regulatory changes to implement the statutory requirement to deny deemed status where CMS requirements are higher than requirements prescribed for accreditation by JCAHO.

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<sup>2</sup> GAO-04-850, *CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals*.

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**Increased Hospital Validation Sample Size.** For FY 2006, CMS has increased the projected number of hospital validation surveys to be conducted from 1 percent to 2 percent. In consideration of accommodating suggested changes to improve sampling as discussed in the GAO report, the additional 1 percent sample will be targeted to those States where a significant volume of accreditation survey activity is expected. The CMS will continue to work towards increasing the number in future years, within the available resources.

**Analysis of Complaint Data.** The CMS is investigating cost-effective approaches to enhance hospital survey activities, including integration of the results of approximately 4,000 complaint investigations conducted in JCAHO accredited hospitals by CMS and the states. The CMS has secured the services of an independent contractor to analyze the hospital complaint data to determine the extent to which this information can be used as an additional tool to assess JCAHO performance.

The CMS will continue to pilot test the mid-cycle survey as an additional tool for measuring JCAHO performance and seek to increase the mid-cycle sample size to enlarge the degree of confidence it has in the findings. The CMS will also continue to explore improved methods of oversight. The CMS will continue to work with JCAHO to obtain more comprehensive and regular information about the organization's accreditation activities and to expedite the exchange of data and information between the two organizations.

# CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

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## Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of FY 2004 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (the College)
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

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The CMS appreciates the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, CMS sees this as an opportunity to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the Nation.

### Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by CLIA, requires any laboratory that performs testing on human specimens to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct Federal oversight by CMS. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is “deemed” to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and others to assure accurate and reliable laboratory examinations and procedures.

In section 353(e)(2)(D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and “such other means as the Secretary determines appropriate.” In addition, section 353(e)(3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

Regulations implementing section 353 are contained in 42CFR part 493 Laboratory Requirements. Subpart E of part 493 contains the requirements for validation inspections, which are conducted by CMS or its agent to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 90 days after the accreditation organization’s inspection on a representative sample basis or in response to a complaint. The results of these validation inspections or “surveys” provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization’s standards and accreditation process; and
- in the aggregate, an indication of the organization’s capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, in section 493.575 of Subpart E, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization’s results and the findings of the CLIA validation surveys, CMS can re-evaluate whether the accreditation organization continues to meet the criteria for an approved accreditation organization (also called

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“deeming authority”). Section 493.575 further provides that CMS has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization’s accreditation process that the requirements are no longer equivalent to CLIA requirements.

### Validation Reviews

The validation review methodology focuses on the actual implementation of an organization’s accreditation program described in its request for approval. The accreditation organization’s standards, as a whole, were approved by CMS as being equivalent to, or more stringent than, the CLIA condition-level requirements,<sup>1</sup> as a whole. This equivalency is the basis for granting deeming authority.

In evaluating an organization’s performance, it is important to examine whether the organization’s inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization’s inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

The organization’s inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one or more of those condition-level deficiencies were present in the laboratory’s operations at the time of the organization’s inspection, yet the inspection results did not note them, the case is a disparity. When all of the cases in each sample have been reviewed, the “rate of disparity” for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by section 493.2 of the CLIA regulations.

### Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to “allow a reasonable estimate of the performance” of each accreditation organization. A representative sample of the more than 15,000 accredited laboratories received a validation survey in 2004. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey, irrespective of the number of accreditations it attains.

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<sup>1</sup> A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, more specific. A condition-level deficiency is an inadequacy in the laboratory’s quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

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Nationwide, fewer than 500 of the accredited laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College, or the Joint Commission, thus the sample sizes for these organizations were larger. The sample sizes are roughly proportionate to each organization's representation in the universe of accredited laboratories. However, true proportionality is not always possible due to the complexities of scheduling.

The number of validation surveys performed for each organization is specified below in the summary findings for the organization.

### Results of the Validation Reviews of Each Accreditation Organization

#### **American Association of Blood Banks**

Rate of disparity: No disparity

Approximately 220 laboratories used their AABB accreditation for CLIA purposes. Three validation surveys were conducted. One case was removed from the review pool for administrative reasons. No condition-level deficiencies were cited on the remaining two surveys, thus disparity was precluded.

#### **American Osteopathic Association**

Rate of disparity: No disparity

For CLIA purposes, approximately 35 laboratories used their AOA accreditation. One validation survey was conducted. A condition-level deficiency was cited in that survey, and the AOA inspection findings were similar—thus there was no disparity.

#### **American Society of Histocompatibility and Immunogenetics**

Rate of disparity: No disparity

Approximately 125 laboratories used their ASHI accreditation for CLIA purposes. Three validation surveys were conducted. Condition-level compliance was found in all the validation surveys, thus disparity was precluded this year, as in the previous years of CLIA validation review.

#### **COLA**

Rate of disparity: 1 percent

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Validation surveys were conducted at 170 COLA-accredited laboratories. One survey was removed from the review pool due to administrative reasons. Of the remaining 169 surveys, seven laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by COLA in six out of the seven laboratories cited with condition-level deficiencies.

Following is a listing of the laboratory identification number, location and condition-level deficiency of the laboratory where COLA findings were disparate.

<u>CLIA number</u>	<u>Location</u>	<u>CLIA Conditions</u>
52D0395048	Wisconsin	Laboratory Director—fulfillment of responsibilities for overall management and direction

### College of American Pathologists

Rate of disparity: 7 percent

A total of 92 validation surveys were conducted at laboratories accredited by the College. Six of the 92 surveys were cited with condition-level deficiencies. Comparable deficiencies were not noted by the College in all six of the laboratories cited with condition-level deficiencies.

Following is a listing of the CLIA identification number, location, and condition-level deficiencies of the laboratories where the College's findings were disparate.

<u>CLIA number</u>	<u>Location</u>	<u>CLIA Conditions</u>
05D0701603	California	General Laboratory Systems
21D0219647	Maryland	General Laboratory Systems Preanalytic Systems Laboratory Director—fulfillment of responsibilities for overall management and direction
21D0693562	Maryland	Cytology General Laboratory Systems
34D0246093	North Carolina	Laboratory Director—fulfillment of responsibilities for overall management and direction
44D0315327	Tennessee	Immunohematology
52D0394346	Wisconsin	Hematology

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### Joint Commission on Accreditation of Healthcare Organizations

Rate of disparity: 4 percent

During this validation period, a total of 110 validation surveys were conducted at laboratories accredited by the Joint Commission. Seven laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by the Joint Commission in three of the seven laboratories cited with condition-level deficiencies.

Following is a listing of the CLIA identification number, location and condition-level deficiencies of the laboratories where the Joint Commission's findings were disparate.

<u>CLIA number</u>	<u>Location</u>	<u>CLIA Conditions</u>
04D0865608	Arkansas	Analytic Systems Laboratory Director—fulfillment of responsibilities for overall management and direction
52D0397602	Wisconsin	Laboratory Director—fulfillment of responsibilities for overall management and direction
36D1006899	Ohio	Laboratory Director—fulfillment of responsibilities for overall management and direction
17D0689019	Kansas	Proficiency Testing—Enrollment

## Conclusion

The CMS has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. The findings of the validation review for fiscal year 2004 indicate that all of the accreditation organizations performed at a level well below the 20 percent disparity threshold that would trigger a deeming authority review. Moreover, there was no indication in the validation review that would raise questions about the overall equivalency of any organization's accreditation standards.

# Glossary

## A

**Accrual Accounting:** A basis of accounting that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual net income.

**Actuarial Soundness:** A measure of the adequacy of Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) financing as determined by the difference between trust fund assets and liabilities for specified periods.

**Administrative Costs:** General term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. The CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, and rent and utilities). These costs are accounted for in the Program Management account.

## B

**Balanced Budget Act of 1997 (BBA):** Major provisions provided for the State Children's Health Insurance Program, Medicare+Choice (currently known as Medicare Advantage), and expansion of preventive benefits.

**Beneficiary:** A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an enrollee).

**Benefit Payments:** Funds outlayed or expenses accrued for services delivered to beneficiaries.

## GLOSSARY

### C

**Carrier:** A private business, typically an insurance company, that contracts with CMS to receive, review, and pay physician and supplier claims.

**Cash Basis Accounting:** A basis of accounting that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

**Clinical Laboratory Improvement Amendments of 1988 (CLIA):** Requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services and have in effect an applicable certificate.

**Cost-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP):** A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

### D

**Demonstrations:** Projects and contracts that CMS has signed with various health care organizations. These contracts allow CMS to test various or specific attributes such as payment methodologies, preventive care, and social care, and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

**Discretionary Spending:** Outlays of funds subject to the Federal appropriations process.

**Disproportionate Share Hospital (DSH):** A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

**Durable Medical Equipment (DME):** Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

**Durable Medical Equipment Regional Carrier (DMERC):** A company that contracts to process Medicare claims for Durable Medical Equipment (DME).

## GLOSSARY

### E

**Expenditure:** Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

**Expense:** An outlay or an accrued liability for services incurred in the current period.

### F

**Federal General Revenues:** Federal tax revenues (principally individual and business income taxes) not identified for a particular use.

**Federal Insurance Contribution Act (FICA) Payroll Tax:** Medicare's share of FICA is used to fund the HI trust fund. Employers and employees each contribute 1.45 percent of taxable wages, with no compensation limits, to the HI trust fund.

**Federal Medical Assistance Percentage (FMAP):** The portion of the Medicaid program that is paid by the Federal government.

**Federal Managers' Financial Integrity Act (FMFIA):** A program that identifies management inefficiencies and areas vulnerable to fraud and abuse so that such weaknesses can be corrected with improved internal controls.

**Fiscal Intermediary (FI):** A private business—typically an insurance company—that contracts with CMS to process hospital and other institutional provider benefit claims.

### H

**Health Care Prepayment Plan (HCPP):** A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Major provisions include portability provisions for group and individual health insurance, establishes the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

## GLOSSARY

**Hospital Insurance (HI):** The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Part A.

### I

**Information Technology (IT):** The term commonly applied to maintenance of data through computer systems.

**Internal Controls:** Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as management controls.

### M

**Mandatory Spending:** Outlays for entitlement programs such as Medicaid and Medicare benefits.

**Material Weakness:** A serious flaw in management or internal controls requiring high-priority corrective action.

**Medical Review/Utilization Review (MR/UR):** Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

**Medicare Advantage (MA) Program:** This program reforms and expands the availability of private health options that were previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organizations plans as well as a new process for determining beneficiary premiums and benefits. Title II of MMA modified and renamed the existing Medicare+Choice program established under title XVIII of the Social Security Act to the MA program.

**Medicare Current Beneficiary Survey (MCBS):** A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

**Medicare Contractor:** A collective term for the carriers and intermediaries who process Medicare claims.

**Medicare Integrity Program (MIP):** A provision in HIPAA that sets up a revolving fund to support the CMS program integrity program.

**Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA):** Legislation passed that establishes a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which will become available on January 1, 2006. It also provides Medicare beneficiaries the option to enroll in the Prescription Drug Discount Card program until the Part D benefit becomes available. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

## GLOSSARY

**Medicare Trust Funds:** Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

**Medicare Secondary Payer (MSP):** A statutory requirement that private insurers who provide general health insurance coverage to Medicare beneficiaries must pay beneficiary claims as primary payers.

### 0



**Obligation:** Budgeted funds committed to be spent.

**Outlay:** Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits.

### P



**Part A:** The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or “HI.”

**Part B:** The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or “SMI.”

**Payment Safeguards:** Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

**Program Management:** The CMS operational account. Program Management supplies CMS with the resources to administer Medicare, the Federal portion of Medicaid, and other CMS responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

**Provider:** A health care professional or organization that provides medical services.

### Q



**Quality Improvement Organizations (QIOs):** Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and is of acceptable quality.

## GLOSSARY

### R

**Recipient:** An individual covered by the Medicaid program (also referred to as a beneficiary).

**Reportable Condition:** A matter coming to the auditor's attention that should be communicated because it represents either an opportunity for improvement or a significant deficiency in the design or operation of the internal control structure.

**Revenue:** The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

**Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP):** A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

### S

**Self Employment Contribution Act (SECA) Payroll Tax:** Medicare's share of SECA is used to fund the HI trust fund. Self-employed individuals contribute 2.9 percent of taxable annual net income, with no limitation.

**State Certification:** Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

**State Children's Health Insurance Program (SCHIP) (also known as Title XXI):** A provision of the BBA that provides federal funding through CMS to States so that they can expand child health assistance to uninsured, low-income children.

**Supplementary Medical Insurance (SMI):** The part of Medicare that pays physician and supplier claims, also referred to as Part B.

### T

**Ticket to Work and Work Incentives Improvement Act of 1999:** This legislation amends the Social Security Act and increases beneficiary choice in obtaining rehabilitation and vocational services, removes barriers that require people with disabilities to choose between health care coverage and work, and assures that disabled Americans have the opportunity to participate in the workforce.

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### **Centers for Medicare & Medicaid Services**

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**T**he Chief Financial Officers (CFO) Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report. The form and content of this ***Financial Report*** follows guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects the Centers for Medicare & Medicaid Services's support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.



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